REPORT OF THE WORKING GROUP ON

HEALTH FOR ALL BY 2000 A.D.

GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE

25TH MARCH, 1981

DIRECTORS CPHE
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PREFACE

The realisation of the social objectives enshrined in our Constitution has been sought to be secured through the national planning process. With the successive Five Year Plans, and the sustained efforts at implementation, we have achieved a significant improvement in the health status of the people of our country. The mortality rate has declined from 27.4 (1941-51) to an estimated 14 (1980). The life expectancy at birth has gone up from 32 years (1951) to over 52 (1980). The infant mortality rate has come down from 135 (1973) to 125 (1978). Plague, which was a common killer disease, is not heard of now. Smallpox has been eradicated. Malaria which, prior to 1950, used to take a heavy toll of about 8 lakh lives, with an incidence of about 7.5 crore cases a year, has been controlled to a large extent, the incidence having fallen to 24 lakhs and less than 200 deaths in 1980.

In spite of these various mentionable achievements, the health care system in the country continues to suffer from several deficiencies. Many eradicable diseases like Tetanus, Polio, Goitre, Tuberculosis, Leprosy, Blindness, Guinea Worm, etc., which could be by and large eliminated, still have fairly extensive incidence in the country. Diarrhoeal diseases continue to be a menace, accounting largely for the high rate of infant mortality which has dropped by only 10 points in the last three decades. Most of our villages do not still have a source of safe drinking water supply, resulting in the prevalence of a variety of water-borne diseases. Also, there are serious locational and qualitative imbalances in the services provided to the various sectors of the population.

The health care measures formulated and implemented in the successive Five Year Plans have generally been based on the approaches recommended by the Bhore Committee (1946) and the Mudaliar Committee (1961). However, in recent years, there has been considerable rethinking on the social, economic, technological and philosophical aspects of the health services structure in the country. There has been growing public dissatisfaction with the existing pattern of medical education and the health services delivery structure, with their high emphasis on hospital-based curative services, development of specialities and super-specialities which, in practice, restrict the coverage of services mostly to the urban areas and the well-to-do classes. Most of our medical graduates rush to seek higher qualifications and, thereafter, naturally look for comfortable and attractive assignments. However, even the specialist services are imbalanced, there being sustained shortages in essential branches like Radiology, Anaesthesiology, Pathology, Microbiology, Nephrology, etc. While there has been an excessive pre-occupation with the promotion of clinical and curative departments, a network of emergency and accident services, which would benefit one and all, has not been sufficiently developed. The concept of health in all its manifestations, with adequate emphasis on the preventive, promotive and rehabilitative aspects, is still to be made operational.

On account of its sustained devaluation *vis-a-vis* other growing specialities, Public Health has become almost unknown as a discipline. This has resulted in the sad neglect of public health administration almost all over the country, leading to numerous, avoidable consequences of ill health.

The Prime Minister has pointed out that the needs of the many must prevail over those of the few. In this context, our tribal, rural and remote areas, urban slums and the economically backward classes need much better attention than that they have been receiving.

India is a party to the universal commitment to secure Health for All by 2000 A.D. Planned fertility regulation is also sought to be achieved, to secure a growth rate of 12 per thousand, by the turn of the century. Uncontrolled growth would negative all progress not only in health but also in the various sectors of the national economy.

An investment on health is investment on man and on improving the quality of life. As such, the improvement in the health status of the people has to be considered in its totality, as a part of the overall strategy of human resource development. Linkages have necessarily to be established with integrated rural development, education, social welfare, agriculture, industry, transportation etc., to ensure the success of programmes for protected water supply, environmental sanitation and hygiene, nutrition, health education, family planning and maternity and child welfare etc. For example, an increase in the rate of female literacy is bound to have an impact on family planning, as has been witnessed in other countries. Similarly, diseases of various kinds could be reduced or eradicated through potable water supply in every habitation. The objective of Health for All can be secured only through a highly coordinated and integrated approach, involving all related sectors.

With a view to evolving a national strategy for securing the objective of Health for All and to identify specific programmes for the VI Five Year Plan, efforts were launched as early as in February 1980. All related Departments, *viz.* Social Welfare, Education, Works and Housing, Rural Reconstruction, Drugs etc., were involved in discussions along with the representatives of the Indian Medical Association, voluntary organisations in the field of community health, social scientists, planners, economists, demographers, etc.,as well as selected representatives from the States and Union Territories. After the various important issues had been identified, I established five Sub-Groups to go into and make considered recommendations on the Meaning of Primary Health Care in the Indian context, Role of Voluntary Organisations, Community Participation, Health Services Structure and Inter-Sectoral Co-ordination. Each of these Sub-Groups had as members eminent medical scientists and other experts. A copy each of the Reports of these Sub-Groups is annexed. The Joint ICMR-ICSSR Study Group had also been established by the Indian Council of Medical Research and the Indian Council of Social Science Research to evolve alternative strategies for Health for All.

In this background, a Working Group on Health was constituted by the Planning Commission to identify in programme terms, the goal for Health for All by 2000 A.D., and to outline, with that perspective, the specific programmes for

the Sixth Five Year Plan.

The Working Group, besides identifying and setting out the broad approach to planning for the Health Sector in the next five years, has also evolved fairly specific indices and criteria to monitor and assess, in quantifiable terms, progress achieved in the various crucial sectors, as a result of efforts to be made. The achievement of the various targeted goals would symbolise the practical extent to which we can secure Health for All in the country by 2000 A.D.

I am confident that the Report in the pages following as well as the five Sub-Group Reports, also annexed, would provide useful material to all those involved, individually and collectively, in the national health effort.

I am grateful to all the eminent experts who gave freely of their time to enable the Working Group to produce this report. I also appreciate the efforts put in by my officers in supporting the functioning of the Working Group.

Kripa Narain

(KRIPA NARAIN)
Secretary to the Government of India
Ministry of Health and Family Welfare
and
Chairman, Working Group on Health

New Delhi
25th March, 1981

REPORT OF

THE

WORKING GROUP

ON

HEALTH FOR ALL BY 2000 A.D.

Introduction

The Working Group on Health was constituted by the Planning Commission with Shri Kripa Narain, Secretary, Ministry of Health and Family Welfare, as its Chairman, *vide* No. HIL-1(1)/80 dated 18th July, 1980. The members of the Working Group were indicated by the Planning Commission, but further co-option was left to the Chairman. A list of those who participated is at Annexure I. The terms of reference of the Working Group were:

1. To review the current health status keeping in view the physical and qualitative implementation of Plan programmes, short-falls and deficiencies and measures for rectifying them.

2. To evolve Plan outlines for 1980-81 to 1984-85 for the Health Sector programmes and suggest measures, including inter-sectoral support and community participation, so that the foundation is laid for achieving Health for All.

3. To suggest specific programmes to benefit rural, tribal/backward areas and weaker sections/slum dwellers and to review the health component of the Minimum Needs Programme.

2. The Secretary, Ministry of Health and Family Welfare, had earlier called two meetings in December 1979 and February 1980, to go respectively into the population issues and the means of achieving the objective of Health for All by the year 2000 A.D. The reports of the Sub-Groups constituted at the meeting in Feb. 1980, alongwith the draft report of the Study Group set up jointly by the Indian Council of Social Science Research (ICSSR) and the Indian Council of Medical Research (ICMR) entitled "Health for All: An Alternative Strategy" were available to the Working Group on Health. Many of the participants at these forums were associated with the Working Group on Health for All by 2000 A.D.

3. This Working Group on Health held four meetings under the Chairmanship of Shri Kripa Narain, Secretary, Ministry of Health and Family Welfare, Govt. of India, New Delhi. The report in the paras following was evolved on the basis of the valuable ideas and suggestions that emerged during the lengthy deliberations and interaction among the members of the Group. The Group expects that its report will be seriously examined by the various States/Union Territories and all other concerned organisations to evolve suitable, viable strategies for the implementation of health care programmes to move towards the goal of "Health for All by the year 2000 A.D." in India.

4. At the very outset, the Working Group on Health recognised that the multi-dimensional development of the human being and the integrated, planned development of his surroundings, should be the core objective of all developmental

efforts. The role of health care is crucial in such a development process. While sound health in all respects - physical, social, environmental, cultural, intellectual and spiritual - is an important and inescapable input into any other developmental or productive activity, it is also, at the same time, the result of synergistic action among all other such activities. This involves the laying of long-term perspectives with short-term population goals. Also, proper health care being a matter of daily personal action of individuals and families, the upgradation of knowledge and individual skills with community orientation and participation, become inevitable. The emphasis on health should also shift from disease and disability cure to the care aspects and recognise the due importance of all aspects of the health system - preventive, promotive, curative and rehabilitative. India is a signatory to the Alma Ata Declaration, committing itself to achieving Health for All by 2000 A.D. India is also a signatory to the South East Asian Charter on Health. The Working Group kept these commitments in view, while evolving its recommendations. The Working Group also duly considered and took into account the recommendations of the earlier groups constituted by the Ministry of Health and Family Welfare, from time to time. The Report contains a variety of inter-related recommendations, setting out objectives, strategies and operational goals which are considered feasible in the obtaining conditions. The report in the paras following, avoids rhetoric, and has not included the narration and the argumentation leading to the inferences and conclusions. It is basically aimed at to set down the parameters of the problems and the specific tasks and targets and to state, in the simplest terms but with the full belief, that the goal of Health for All as spelt out here is an achievable one, given the sustained will and the supporting efforts to implement the indicated tasks.

Objective

5. The fundamental objective of the State and national health plans should be to organise and provide universal primary health care and medical services to all sections of the society with special attention to the needs of those living in the tribal, hilly and remote rural areas. Special plans should be prepared to service such areas. The public health, preventive, promotive and rehabilitative aspects of health care should dominate over the purely clinical, hospital-oriented services. To achieve this end, concrete action plans would have to be devised and implemented.

5.1 Extensive exercises have been carried out by the Ministry in regard to the nature of changes required to be brought about in the health services structure in the States and Union Territories. The reports of the 5 Sub-Groups (appended) were forwarded to all the States/Union Territories in March 1980 and a national level meeting was specially convened in April 1980 to urge all the State Governments to carry out the requisite exercises to frame well-considered plans for achieving the objective of Health for All by 2000 A.D. They were specially urged to give practical shape to the Prime Minister's exhortation that the "needs of the many should prevail those of the few".

5.2 In formulating future plans and programmes, the States/Union Territories would require to devote very special attention to organising and providing a minimum package of services which, *inter-alia*, must include:

1. Universal provision of promotive, preventive and basic curative services. The preventive and public health aspects shall have to be secured through well-organised programmes of health education, specially in regard to prevailing health problems.

2. Organising special plans to provide health care including family planning to the vulnerable groups *i.e.* children and pregnant women.

3. Prevention and control of endemic communicable and non-communicable diseases

   - through immunisation (EPI target diseases);

   - through appropriate measures (Leprosy, Tuberculosis, Goitre and curable blindness);

   - interruption of transmission of vector-borne diseases (Malaria, Filaria and Kala-azar);

   - reduction of diarrhoeal-diseases-mortality through application of oral rehydration therapy and of intestinal parasitic infestation morbidity through enforcement of appropriate community measures.

4. Activities directed towards the promotion of food supply and the improvement of nutritional status.

5. Provision of protected water supply and sanitary disposal of excreta.

6. Population education to enable people to appreciate, adopt and consciously practise the small family norm as part of the way of life.

6. The Health indicators/targets as given in Annexure II have been finalised by the Working Group after detailed deliberations with the concerned experts, and taking into account the exercises made in this connection by the sectional heads in the Ministry. It is recommended that the country should aim to achieve these to attain the overall objective of Health for All by the year 2000 A.D. For each State, Union Territory and area, these indicators/targets would have to be further broken up into concrete figures, taking relevant data and local conditions into consideration.

Revised Minimum Needs Programme

7. Realising the need to develop a comprehensive national health policy and to create an alternative model of health care service, keeping the objective of Health for All by 2000 A.D. in view, the Group felt that the existing health care delivery system should be restructured so as to integrate the promotive, preventive and curative aspects at all levels of primary health care. Subject to the local topography, density of population, transport systems etc., the following model of health services structure is recommended. Each State/Union Territory would have to undertake careful exercises to review the available structure and to adopt the recommended model with such local variations as may be required, to adequately meet the local requirements.

For each District

District Health Centre with specialised curative services and public health experts.

For each Sub-Division/Approximate 5 lakh population

A sub-Divisional Health Centre with epidemiological wing attached to it.

For each Block/one lakh population

A Community Health Centre with specialised medical care services in Gynae, Paediatrics, Surgery and Medicines (out of the 4 non-specialised doctors, one may be drawn from any of the locally accepted traditional systems of medicine and one should be a public health man). The recommended staffing pattern for the Community Health Centre is given in Annexure III.

For 30,000 population (or 15,000-20,000 in the case of hilly, tribal, sparsely populated or desert areas)

A Primary Health Centre (PHC) fully equipped to render preventive, promotive and curative services. The staffing pattern is given in Annexure III A.

For 5,000 population (or 2,500 population in the case of hilly, tribal, sparsely populated or desert areas)

One Sub-Centre having one MPW(F), MPW(M) and one part-time attendant.

For each village/1000 population (or 500 population in the case of hilly and tribal areas or sparsely populated or desert areas)

One Health Volunteer preferably Female, Ex-Serviceman, School Teacher, Village *Vaidya* or Village *Dai*, etc.

7.1 The objective should be to adopt a decentralised, participatory approach involving the community intimately in the planning, implementation and maintenance of the health services.

Recommended Guidelines for the Establishment of PHCs and Sub-Centres

8.1 The Group accepted the fact that no patent guidelines would be appropriate or relevant in so far as the establishment of new PHCs/Sub-Centres is concerned as the situation varies not only from State to State but even from PHC to PHC within a district. However, taking all aspects in view, the Group recommended the following guidelines, for adoption after local modifications, as per actual requirements:

1. The proposed Community Health Centre and the new PHCs may be established by upgrading the existing PHCs and Dispensaries (Allopathic/ Traditional Systems of Medicine) respectively, in the rural areas.

2. At present a good number of PHCs are located at Tehsil/Sub-Divisional/ Taluka headquarters which also have hospitals. Such PHCs may be shifted to the interior rural areas.

3. The District Hospitals should be converted into District Health Centres.

4. Barring cases of indigent patients for whom services and care at all levels of the structure should be totally free of charge, each State/ Union Territory should evolve a graded system of payments related to the socio-economic levels of the beneficiaries for diagnostic tests, indoor hospital treatment, etc. This shall be enforceable from the level of District Health Centre upwards to the highest specialised Centre. Consequently it shall be necessary and obligatory for each State/Union Territory to enforce a strict system of referrals, commencing from the Community Health Centre level. However, depending upon the nature of the ailment and the kind of treatment necessary, the Specialist at the CHC may refer a patient directly to the State level hospital or the nearest/appropriate Medical College Hospital, as may be necessary, without the patient having to go first to the Sub-Divisional or the District Health Centre.

5. One of the 3 doctors at the CHC level may be from one of the locally acceptable traditional systems of medicine and one of them must possess Public Health qualifications and experience.

6. As difficulties may arise in securing the services of an adequate number of Specialists for the CHCs, it is recommended that, in the initial stages, the gap may be filled up by having specialised training imparted to the graduate doctors in each concerned field. State Governments should plan their requirements of training in this regard.

9. Adequate and effective provision of primary health care services should be made in the urban slums. Each urban slum, with a population of 5,000 or more, should have a Health Post which would form an extension of the hospital located nearest to the slum area. The Post should be manned by an Auxiliary Nurse Midwife residing in the locality nearest to the slum and be assisted by two nearest located lady social workers.

10. To be implemented, the above recommendations would involve considerable augmentation in the existing health infrastructure. The additional requirements of manpower and other facilities required to be developed by the year 2000 A.D. would, therefore, require to be phased out, Plan-wise and annually. Taking the country's needs in view a macro-level phasing has been done, which may be seen in Annexure IV. It would be urgently necessary for each State/Union Territory to undertake suitable exercises to evolve a phased action plan, taking into view what already exists on the ground and what would be required to be established by 2000 A.D.

11. Apart from fulfilling the needs arising from the establishment of the proposed new centres, the backlog of the previous Plans will also have to be

made good. This is estimated to involve a specific outlay of Rs.1,896 crores in the Sixth Five Year Plan (See Annexure V). Out of this a sum of Rs.1,200 crores approximately is estimated to be spent on construction activity alone. Keeping the financial constraints in view, efforts will have to be made to effectively mobilise community participation on a progressive basis to share the burden of the cost of construction.

12. In respect of the other targets relating to the Minimum Needs Programme, efforts should be made to at least achieve 25% coverage during the year 1980-85.

Water Supply and Environmental Sanitation

13. Provision of potable water supply to the rural areas is pivotal to achieving the goal of "Health for All by 2000 A.D.". Linked with this are the schemes for the proper disposal of human and animal wastes and sewage/sullage. In this regard the following recommendations are made:

1. Planned and coordinated efforts should be made to provide potable water to the entire rural population by the year 1990, as already planned under the Water Supply and Sanitation Decade.

2. In pursuing the goal at (1) above, the following order of priorities is recommended:

   a. Coverage of habitations in which there is no source of water supply within 1.6 Kms. or where the potable water is not available within a depth of 50 feet or the areas which are endemic to Cholera, Guinea-worm infestation or those which suffer from excess of salinity, iron or fluorides or other toxic elements hazardous to health, etc. Such habitations should be fully covered by 1985 with adequate sources of potable water supply. About 2,10,000 villages have been identified under this category by the Ministry of Works and Housing.

   b. Those villages where 100% coverage of population has already been achieved by drilling of tubewells etc. but for want of energy and manpower the same have not become effective or where the tubewells established earlier are not functioning due to lack of maintenance etc. This inadequacy should be entirely removed by 1985 at the latest.

   c. Coverage of those habitations in which water supply schemes have already been established but adequate supplies according to the needs of the population have not yet been established. 100% coverage of population should be aimed at for this category, by 1990.

14. Ways and means should be found for entrusting the running and maintenance of water supply schemes to the community and ensuring that the drinking water supply through these schemes is really safe and potable. In addition, low cost

technology, easily understood and operable by rural people needs to be developed for the treatment of existing sources of water supply at source *viz.* wells, tubewells, pipeheads etc.

15. In order to establish a coordinated approach for implementing the National Water Supply Programme, a Coordination Committee comprising of the representatives of the Planning Commission, Ministry of Health and Family Welfare, Ministry of Works and Housing, Department of Rural Reconstruction, Department of Social Welfare, ICMR and NEERI should be formed at the Centre. This Committee should consider such important policy issues *e.g.* raising of funds from the community for meeting the running and maintenance costs, ensuring community involvement in the construction, proper use and maintenance of works etc.

16. Alongwith the provision of potable water supply, it is equally necessary to ensure good sanitation and disposal of human and animal wastes. The Group is of the view that by 1985 efforts should be made to achieve atleast 10% coverage in the rural areas and 60% coverage in the urban areas which should be stepped up to 50% and 80% respectively by 1990 and to 100% by 2000 A.D. In every village where water is being supplied, simultaneous efforts must be made to arrange environmental sanitation. There should be a close collaboration with the Ministries of Agriculture and Rural Development in respect of composting and/or gobar gas generation in order to attack and reduce the sources of diseases, specially as a large number of them arise from waste water, garbage, human and animal wastes etc.

Manpower Development

17. The Group is of the considered view that there should be a cadre of Community Health Officers constituted by public health trained and oriented personnel. This should initially be created by giving suitably desired in-service training in public health, preventive and social medicine etc. to the existing Health Supervisors who have functioned as such for 5/7 years. This will not only provide promotional avenues but also serve as an incentive for more dedicated work in the field of public health.

18. All the personnel involved in the traditional systems of medicine should also be trained in the preventive and promotive aspects of health care.

19. The training of para-medical workers in Malarialogy, Leprosy, T.B. and Ophthalmology should be intensified during the Sixth Five Year Plan with a view to ensure that specific requirements of these major health programmes are fully met.

20. A tabular presentation indicating Health Manpower Requirements upto the year 2000 A.D., in accordance with the revised Minimum Needs Programme as given under Paras 7 to 16 above, is indicated in Annexure VI.

21. The National Medical and Health Education Policy to be formulated and finalised must take into account the various requirements.

Incentive for Rural Service

22. At present the doctors posted in the rural areas in government service,

are not only handicapped in terms of physical and social facilities, but also loose financially due to non-admissibility of certain allowances for which their counterparts posted in the urban areas are entitled. To encourage the doctors to willingly accept jobs in the rural areas, the Group recommends the grant of the following incentives to them:

i. A Rural Posting Allowance of Rs.150/- p.m.

ii. The non-practising allowance for doctors posted in the rural areas may be 50% more than that admissible for posting in the urban areas.

iii. An Education Allowance, for children below the age of 16 years, at the rate of Rs.50/- p.m. per child.

iv. Rent free residential quarters, failing which H.R.A. at 15% of pay including N.P.A.

v. In case the doctor's family is staying in some town, the C.C.A. and House Rent Allowance as admissible for the town, where the family is staying would also be admissible as a family-separation allowance.

vi. After five years of rural service, the doctor may be given as far as possible a posting at a station of his choice.

vii. For any further training including post-graduation at government cost, minimum three years rural service should be an essential condition.

viii. All the para-medical staff posted in the rural areas should be given free residential accommodation or H.R.A. at 20% of pay and allowances in lieu thereof.

Employment of Unemployed Doctors

23. The private practitioners are an essential component of the health care system in the country. As such, any government plan to provide health care in the rural areas must encourage private doctors to settle in the rural areas. In order to encourage young doctors to settle in the rural areas identified as priority areas, the following incentives are suggested:

i. Admissibility of loans upto Rupees one lakh from Nationalised Banks, at the rates of interest applicable to loans advanced for establishing industries in the backward areas.

ii. Admissibility of subsidy in capital goods like equipment etc. on the same basis as in (i) above.

iii. If the doctor settles in any village, where at present there is no doctor and agrees to provide (a) part-time services twice a week to the Sub-Centre of the area; and (b) regular health check-up at least once in every quarter to the children in schools within the Sub-Centre area, he may be given an honorarium of Rs.500/- per month.

iv. Allotment of government/panchayat land at concessional rates for the construction of his residence and clinic.

Approach and Strategy

24. It is necessary to develop nodal points of local contact in the field of Health in every village in the country. This is necessary to achieve the transfer of knowledge, skills and responsibility for health care to the community at large. To attain this objective, it is recommended that known social workers in each village are identified and designated as Swasthya Sahayaks. The Swasthya Panchas should be answerable to the Panchayat/Village Health Committee.

25. In order to bring about a sense of accountability among the medical and para-medical workers at various levels, there should be a Health Advisory Committee for each PHC which should include representatives from various cooperative societies working in the area, voluntary organisations, village panchayats including Swasthya Panchas if any, in addition to the State Government nominees. These Committees should ensure monitoring and evaluation of the various health schemes and targeted health indicators. Their findings should be fed into the decision-making processes to enable the corrective measures necessary for the development of a sound health care delivery system, in each local area.

26. The Health Advisory Committees should also be entrusted with the responsibility of raising financial resources from the community for improving the health care delivery system in their areas. Cooperative Societies, particularly Milk Societies, Silk Societies and Handloom Societies which together cover a large part of the country, may be encouraged to establish Sub-Centres/PHCs with contributions and participation from the community and appropriate grants-in-aid from the Government.

27. The financial pattern of identified Centrally sponsored health schemes, which comprise of and relate to various rural health programmes, primary health care in any given sector, eradication of communicable diseases like T.B., Malaria, Filaria, and control and eradication of Blindness, Leprosy, Polio, Tetanus, Guinea-worm, Goitre, etc. should be on the basis of 100% assistance from the Central Government which should also be responsible for monitoring and evaluation thereof. The role and the responsibility of the Central Government, Local Bodies, Community and Voluntary Organisations under the various Plan schemes should be clearly defined and assigned.

28. There should be regular training, reorientation and continuing education programme for all categories of medical and para-medical workers. Health Education and School Health Programmes should be strengthened and intensified in all the States with a view to laying stress on the public health, preventive and promotive aspects of health care.

29. Keeping in view the indicated targets given in Annexure II for achieving Health for All by 2000 A.D. efforts should be made to achieve 100% progress under the Expanded Programme for Immunisation, not only for DPT, DT and TT, but

also for Polio and Typhoid by the year 1990. Physical targets have been given in the said Annexure in respect of Water Supply, Sanitation,Nutrition, Malaria, T.B., Leprosy, Blindness, Goitre, Guinea-worm, Scabies, Diarrhoeal diseases, Filaria, Dental diseases, Mental Health, School Health etc. etc. Every State/ Union Territory must evolve detailed area-wise plans for the achievement of the stipulated targets in each sector.

30. Past experience in the implementation of programmes for the benefit of weaker sections, particularly in backward, rural and tribal areas, has clearly indicated the effectiveness of area based integrated delivery systems taking into consideration the inter-linkages and the necessary supporting services in each geographical area. Without supportive services like water supply, nutrition and health education of mothers, environmental sanitation and hygiene, health services will not have the full impact. While planning for the expansion of health services, the strategy should be to secure the convergence of all the supportive services. Similarly, in areas where other services like special nutrition programmes are in operation, coverage by child health services may be secured rapidly so as to derive the full synergistic benefit of the health and nutrition services.

31. More emphasis and support should be given to such coordinated research project as can produce quick results for immediate translation into action, with a view to improving the health care facilities.

32. Each State Government/Union Territory Administration may consider launching Health Insurance Schemes, as pilot projects, on experimental basis, both for urban and rural areas so that the scheme, if successfully established can be extended further.

33. Private practice by government doctors has a very adverse effect on and interferes seriously with the health care delivery system, even in the curative field. The Working Group strongly recommends that in future, Central assistance for health care schemes may go only to those States and Union Territories which undertake to totally ban private practice by Government doctors, and in all Medical Colleges/Institutions.

34. In the implementation of the proposed strategy, growing burden will have to be shared by the voluntary organisations,and private practitioners in the field of health care. It is accordingly recommended that every State Government may devise viable mechanisms to offer suitable incentives as well as financial, technical, infrastructural support to such organisations/persons through scheduled banks or otherwise. The community should also be encouraged to organise primary health care facilities in the rural areas, slums etc.

35. For efforts as in para 34, the smallest unit may be of 5,000 population (the coverage of a Sub-Centre). In such areas, Government may not extend its organisational structure; instead it should provide financial support equal to 75% of the non-recurring and recurring cost which government would have incurred on its Health set up in that area or 75% of the total expenditure incurred by the voluntary organisations/community, whichever is less. Such organisations should get the same technical, referral etc.support from the government organisations as is provided to the government-run Sub-Centres.

36. Planning Commission should develop a mechanism to ensure that the funds provided for the Health sector are not diverted to other areas by the State Governments and that the health schemes are properly implemented. The creation of a health coordination and implementation committee in the Planning Commission for this purpose is recommended.

37. The Group is sensitively cognizant of the fact that the development of good health care service will progress proportionately to the extent to which efforts of the Government and the people to eradicate poverty, inequality and ignorance achieve headway to bring about socio-economic development of the country as a whole.

38. The Group emphasises the need of setting up of special detection and medical rehabilitation services for the physically handicapped persons in each State. The incorporation of principles and fundamentals of rehabilitation work in the MPW Scheme and LHV Scheme is also necessary.

Infant and Child Health

39. A high degree of awareness and concern about the wastage of lives of children requires to be generated, specially as such a realisation has a direct linkage with the success of our Family Planning efforts. Causes of infant mortality are related to immunity, health and nutritional status of pregnant mothers, the process of child birth and the care that the new born infant receives immediately after birth. The Group took note of the 10 major causes of deaths among infants and children (1 to 5 years) identified by the Registrar General of India in his Report relating to Survey of Infant and Child Mortality 1979 (as tabulated in Annexure VII) and felt that programmes like EPI, sustained ante-natal health provision, safe delivery and care of the new borns (including education of mothers), measures to reduce malnutrition amongst infants and children, control of diarrhoeal diseases, control of respiratory diseases amongst children, etc. should be intensified with a view to bring about an effective reduction in the infant mortality rates as envisaged in the health indicators set out in Annexure II.

40. The scheme of prophylaxis against nutritional anaemia amongst mothers and children, prophylaxis against blindness in children, caused by Vitamin 'A' deficiency, needs to be vigoroulsy implemented as part of the Family Welfare Programme.

41. Over two-thirds of the country's population falls in the vulnerable category of women and children and need to be provided with some special health care services. Keeping in view the importance of checking the growth rate of population in the country to the bare minimum possible, the Group feels that premium on providing health education, sanitation, safe drinking water, nutrition, immunisation against preventable diseases, etc. has to be placed in organising health care services for women and children, who by themselves form a weaker section of the society.

42. Infant and child mortality are important indicators of the health status of a nation. Their reduction should be one of the major objectives of the

Sixth Plan. The draft National Policy for Children has indicated the policy measures and programmes for improving the health and nutrition status of children. These would have little meaning unless implemented on a time bound basis.

43. To further enhance the value of Integrated Child Development Programmes like ICDS, convergence of protected drinking water supply, environmental sanitation and health inputs in ICDS areas should be ensured so that malnutrition, infant mortality and morbidity can be demonstratively reduced.

School Health Check-up

44. The school health programme for the periodical check-up of school going children should be vigorously implemented by States and Union Territories during the Sixth Plan period. This programme should specially include screening of school children for rheumatic heart diseases and adoption of necessary prophylactic measures to reduce incidence among school children. A scheme should also be drawn up to cover non-school going children with this facility. The efficient and effective implementation of such a programme would besides extending the concepts of health consciousness and prevention of disease amongst the school goers, also have the tremendous advantage of upgrading the levels of awareness of their families as well as of the social groups in which they live.

45. Health check-up including ophthalmic check-up and dental check-up of school children in all the schools of the country should be possible with the expansion of the health delivery system to the village level.

Control of Communicable Diseases

46. During the Sixth Plan period more stress should be laid on survey and detection of the major communicable diseases, and on eradication of the comparatively easily eradicable diseases like Polio, Tetanus and Guinea-worm. Eradication of these diseases would enable us to direct the resources so tied onwards, attacking the remaining ones in a more effective manner. The eradication of Smallpox is a good example of this strategy.

47. The supervision and monitoring of the major national health programmes like Malaria, Leprosy, T.B., Prevention of Blindness,etc. should be strengthened to ensure effective and proper implementation of these programmes.

48. Vigorous efforts should be made for the involvement and parti ipation of the community in these programmes. The services of private practitioners, voluntary organisations, panchayats, school teachers, students, post offices, etc. will have to be mobilised for this purpose.

49. Since large funds are required for the implementation of these programmes, efforts should be made to raise sufficient resources through internal and external aid giving agencies.

50. The research and training components of these programmes need to be stepped

up considerably. This should include detailed epidemiological studies of communicable diseases, their mode of transmission,knowledge of vector biology and eco-systems to enable the development of more effective approaches to the control of vector-borne diseases based on suitable, feasible and cost-effective technologies.

51. The Group noted that in the control of communicable diseases like Malaria, Filaria, Leprosy, Kala-azar, etc. new tools and techniques are required, such as vaccines against Malaria, Leprosy and Kala-azar, better Filaricidal drugs, methods of overcoming Plasmodial resistance of chemo-therapy and vector resistance to insecticides. Basic research projects are recommended to be instituted in this direction.

52. The Group recommends that there should be effective inter-sectoral coordination of the Central Departments of Irrigation, Food and Agriculture, Works and Housing, Energy and Industries to ensure that their in-puts and projects do not create environmental conditions for increase in communicable diseases, like Malaria and Filaria.

Hospitals and Dispensaries

53. The hospital and dispensaries doing only curative work will have to be progressively and effectively involved in the preventive, promotive and public health aspects of health care through establishment of PH/Epidemiological centres attached at all levels from PHCs to District level hospitals. These hospitals will also have to be effectively linked in the referral complex system, besides their responsibility for urban health care. In order to give more autonomy to these hospitals and participation of the urban community in their management, the concept of setting up of the Hospital Corporations is recommended. The addition of beds in the existing institutions should be based on the criteria of felt needs and balanced regional distribution of the health care facilities. The Group recommends that such Hospital Corporations, if set up, should enjoy autonomous status and should work on no-loss no-profit basis. They should necessarily provide at least 20% beds without any charge for hospitalisation of indigent patients and an additional 20% beds for admission of patients having an income of less than Rs.500 per month, on payment of nominal charges only.

54. The development of super-specialities should ensure the twin objectives of meeting the zonal requirements of the country and avoid overlapping to minimise expenditure on too much of sophistication not related to the immediate needs now accessible to the overwhelming majority of the masses.

55. The Government should afford necessary encouragement to non-resident Indian doctors to return home and set up clinics and hospitals. In case such efforts are made in the rural and backward areas, attractive incentives may be extended as earlier stated at paragraph 23.

56. With the rapid industrial development and mechanisation in the fields of bio-medical engineering, electro-medical equipment, sophisticated electronic laboratory and diagnostic equipment, public health engineering systems,teaching

aids, etc. the working group recognised the necessity of setting up of a separate Department in the Central Government to take care of the expansion, growth, standardisation and systematic development of medical industry and research thereunder, in the country. A suitable scheme for the same could be initiated in the Sixth Five Year Plan.

Medical Education Research and Training

57. Under-graduate medical education needs major reforms as the requirements of the medical personnel will be more in the nature of community-oriented general services as compared to specialities and super-specialities in order to achieve the object of "Health for All by 2000 A.D.". Curricular reforms, participation of medical institutions in the health care delivery system, placement of interns in District Health Centres, Sub-Divisional Health Centres, Community Health Centres and Primary Health Centres, instead of teaching institutions etc., need to be implemented on a planned basis.

58. Eligibility for admission to post-graduate courses of medical education should be redefined, presenting that only such graduate doctors who put in at least 3 years of community service in rural areas covered by a PHC, shall be considered for admission in post-graduate courses in clinical subjects. However, no such condition need apply to those seeking admissions to post-graduation courses in public health or any para and non-clinical areas.

59. To develop adequate manpower in the scarce specialities, special incentives for higher studies in identified specialities may be considered.

60. As the needs of specialities and post-graduates in selected super-specialities will be limited in the near future, the pattern of post-graduate medical education will have to be reviewed in order to ensure balance between the requirements and generation of such personnel.

61. The continuing education and in-service education for all categories of personnel need to be developed suitably and made universally available and applicable.

62. Training of public health para-medical personnel need be given the highest priority during the Sixth Plan period.

63. There is need for further development of the training of health educators, as well as training of personnel in health information systems. Management Training needs of all categories of personnel in the field require to be met by suitable programmes developed for this purpose.

64. Emphasis should be placed on linking research projects with the implementation of programmes. The initiating of Coordinated Research Projects, specially such projects which may produce quick results for immediate translation into action, to improve health care facilities, is the need of the day and should have high preference.

65. Development of Health information systems, monitoring systematic review

and evaluation of the programmes, needs to be given due priority. The planning machinery right from the PHC level to State and at Centre should be adequately strengthened. A programme for the development and periodical review of State/National Health Profile alongwith specific health problems/indices of individual States could be initiated immediately.

66. A Health and Medical Education Commission or a suitably high powered, independent and effective organisation should be constituted at the Centre, as soon as possible, to reliably assess the requirements of medical and paramedical manpower, education, research and training of the various systems of medicine prevalent in the country. The Group felt that the success of all future efforts would depend very largely on a coordinated approach towards manpower planning for all levels of the infrastructure.

67. The Group felt that there is need to initiate bio-medical and health services research in support of primary health care to focus on the need for introducing modifications to the existing technologies to suit local conditions and discovering new technologies based on advances in basic sciences and carefully controlled clinical studies. As the actual delivery of the primary health services poses an enormous management challenge, operational research in the delivery systems also requires a very high priority.

68. With increasing life expectancy, cancer and cardio-vascular diseases are assuming greater public health importance. A majority of the cancers are related to environmental influences. Carcinoma of the uterine cervix in relatively young women, oral cancer and cancer of oesophagus are becoming widespread. Likewise, rheumatic heart diseases, the most common form of organic heart diseases, affect young people and those belonging to the underprivileged sections of the society. Hypertensive and ischaemic heart diseases are becoming increasingly prevalent. With high rates of inbreeding in certain communities in the country, genetic disorders are also assuming greater significance. Mental health is already a problem of considerable magnitude. The Group, therefore, recommends studies of these disorders intensively with a view to understanding better their causes and mechanisms, leading to the development of better preventive and therapeutic measures.

Traditional Systems of Medicines

69. Different systems of medicine in vogue in the country are to be encouraged and developed depending upon the popularity of these systems obtaining in different areas. It should however, be ensured that a graduate in any of these systems has a basic knowledge of human anatomy, physiology and other necessary medical knowledge.

70. These systems should supplement and fully coordinate with health care facilities including curative, public health preventive and promotive aspects initiated and developed as part of allopathic systems of medicine. Definite schemes should be drawn up for the active participation of all systems in the national health programmes, such as control of Malaria, Leprosy, T.B., Blindness, etc. for the detection and cure of these diseases with traditional drugs and regimens.

71. The research programmes of the traditional systems of medicine should be expanded. This should include mounting of a concerted effort in developing indigenous systems to provide cure for diseases for which there is no cure available at present in Allopathy, such as Cancer, Diabetes, Leucoderma, Epilepsy, Infective Hepatitis, etc. Methods available in these systems enabling eligible couples to limit their families should also be explored. Greater emphasis will also require to be laid on the use of modern equipment and diagnostic methodology so that the result of research in the traditional systems of medicine becomes more readily acceptable to the modern scientific world.

72. Necessary improvement in the education and training in these systems of medicines should be carried out. One National Institute for each traditional system of treatment should be established so as to produce teachers and clinicians of high calibre in these systems and make the under-graduate and post-graduate education of uniformally good standard, all over the country. This would require upgradation of the staff and equipment in the existing institutions. The Central Councils of Traditional Systems of Medicine should endeavour to lay down gradually a high and uniform standard of teaching and ensure printing and publication of standard textbooks and authoritative reference books.

73. The programme should *inter-alia* encourage cultivation of medicinal plants, adoption of modern technology in the manufacture of traditional medicines, adoption of specified standards to ensure quality of raw materials and manufactured products and promotion of herbal gardens as an integral part of Pharmacies in order to achieve self-sufficiency. The manufacture of standard indigenous drugs may be developed by a programme of support for the selected State Pharmacies. At the Centre, to provide such drugs for the CGHS and for research programmes, a unit under the name of Indian Medicines and Pharmaceutical Corporation may be set up.

74. A definite scheme may be drawn up to translate the basic texts and literature of different traditional systems of medicine in Hindi and English from Sanskrit, Arabic, Tamil, etc. in which these are currently available so that there should be free exchange of information and knowledge among the different systems within the country and abroad.

Drug Standard Control and Prevention of Food Adulteration

75. Steps should be taken to ensure the use of generic names of drugs by the manufacturers, so that avoidable increase in prices because of individualised packaging, advertising, marketing costs for various brand names of the same basic drug could be altogether eliminated. This measure alone would make drugs and medicines available to the consumer at a considerably reduced cost.

76. The regulations in regard to imports, local production, sale and distribution of drugs, maintenance of standards and quality need review to ensure availability and supply of essential drugs on a liberal scale for promoting primary health care. The Ministry of Petroleum, Chemicals and Fertilisers had constituted a Working Group for finalising the demand/estimates of various bulk drugs during the Sixth Five Year Plan period and this group had estimated that the

total value of the bulk drugs for the period 1980-85 would be of the order of about Rs.700 crores and the value of the drug formulations would be of the order of about Rs.2100-2200 crores. As this involves a tremendous increase in the existing level of production of about Rs.210 crores worth of bulk drugs and Rs.1,150 crores worth of drug formulations,expansion of the existing capacity as well as creation of additional capacities will have to be organised. Many important and life saving drugs are still being imported. At least the drugs needed for the National Programmes, like Malaria, T.B. and Leprosy should be manufactured on a priority basis in the country to cater to full requirements of these Programmes.

77. The State Governments which have not yet established Drug Testing Laboratories of their own, should take necessary steps to do so in the Sixth Plan period. The needs of the existing Testing Laboratories should be reviewed to make them work more efficiently and effectively for ensuring quality control of the drugs produced in the country.

78. Effective measures need to be taken to ensure the balance between demand and supply of essential drugs particularly the life saving drugs which, with standard packing under generic names, should be available at much cheaper rates than at present.

79. The different vaccine production units should be strengthened to generate adequate production to meet the requirements of the country for each of the immunisation programmes.

80. Drug abuses should be controlled. Efforts need to be made to ensure preventive measures for the control of drug addiction among the communities exposed to the problem. Treatment of drug addicts should be developed as a part of the general health service in the country. This could be done within the framework of existing Psychiatry Departments of Medical Colleges and in the larger hospitals. In urban areas where the current prevalence of drug abuse is large,separate de-addiction centres may be established for providing comprehensive services.

81. Effective implementation of the Food Adulteration Act and establishment of Food Testing Laboratories as integral parts of Drug Testing Laboratories, setting up of squads for checking specimens of adulterated food and drugs needs to be given priority importance.

Health Education

82. This is the most crucial area requiring attention. Different agencies are operating at the field, to impart health education. Every health worker should be a community health educator. Besides, the school health education and the adult literacy programmes and the organised sector should be involved in the health extension approach.

83. The health education bureaux in the States, Union Territories and at the Centre should be suitably strengthened to coordinate efforts.

84. Adequate arrangements should be made for the health education of trainers at various levels.

School Health Education Programme

85. The school health education programme has not been accorded its due priority during the previous plans by the State and Union Territories. Education has been envisaged as a tool to bring certain behavioural changes in the future citizens of the country. Behavioural change is considered more important than the development of functional awareness about health. For this reason, the National Council of Educational Research and Training has taken up programmes for the effective teaching of concepts pertaining to health. These activities are in the form of instructional materials, live syllabus, textbooks, teachers' guides, laboratory manuals, etc. The concept of health education has to be inducted in different disciplines and presented through reading materials of formal or non-formal education, toys, etc. It is recommended that health education should not remain only within the confines of school education but should also be included actively in the education programme of the colleges and universities and form an integral part of the national medical and health education policy.

86. The Group feels that there is an imperative need to provide health and nutrition education and environmental sanitation particularly in schools in the rural areas as an effective intervention to reduce mortality and morbidity among the children and increased awareness among the community.

87. The Group recommends that the pilot project on Health and Nutrition Education and Environmental Sanitation launched by the Ministry of Education should further develop and provide wider coverage.

88. The Group also recommends that the Population Education Project undertaken by the Ministry of Education should be energetically implemented and continued.

Population Stabilisation

89. India's population is currently increasing at the rate of 2.2% per annum and the population of 683 million, enumerated in the 1981 census, may rise to about 950 million by the year 2000 A.D. As rapid increase in population becomes a continuing drag on the resources of the country, urgent steps are necessary to reduce the rate of population growth. Further the women should be enabled to enjoy their basic human right to decide on the number and spacing of their offspring. Regulated, spaced and limited number of children help mothers, children and families in multifarious ways. Contraceptive knowledge, supplies and services should be available to everyone. The Small Family Norm should get ingrained in the ways of life of the people.

90. The Group recommends that the objective of our Population Policy should be to reduce the net reproduction rate to 1% by 1995. To make the Family Planning Programme effective, it should be built up as part of an integrated package consisting of measures in health care particularly of infants and mothers, the care of the aged, nutrition, water supply and sanitation, health education and

extension. The State and Central agencies should jointly work out an integrated population stabilisation programme with built-in flexibility so that the contents of the programme and the socio-cultural features of the area to be covered are mutually compatible.

Financial Inputs

91. The Group noted that the expenditure on social services sector has been gradually going down from 21% in the First Plan (1951-56) to 13% in the earlier Sixth Plan Document (1978-83). Out of this allocation, the expenditure on the Health Sector has come down sharply from 5% to 1.8%, during the said period. Not only that, even the percentage of expenditure on Health Sector to the total outlay for the social sector has been showing downward tendency from 29.6% in the Second Plan (1956-61) to 14% of the outlay proposed for 1978-83 (Appendix VIII). It is unfortunate that the social services sector in general and the Health Sector in particular have not been given due importance in the Plan outlays, although it has been realised in all quarters that human welfare has to be the supreme consideration of all the development Plans and programmes.

92. On the basis of the recommendations of the Group contained in the paras foregoing, it is estimated that, keeping the objective of Health for All by the year 2000 A.D. in view, a total Plan outlay of about Rs.4,000 crores for the Sixth Five Year Plan for the Health Sector alone would be needed. In addition, an outlay of about Rs.1,400 crores for Family Welfare Programmes would be required for the same period. Thus, the total requirement for the Health and Family Welfare Programmes would work out to Rs.5,400 crores for the revised Sixth Plan (1980-85). For the year 1980-81, no change in the concept and approach is recommended, to avoid any confusion at this late stage.

Policy Statements

93. It is urgently necessary that the Government of India evolve and issue well considered national policy statements in regard to:

i. National Health Policy

ii. National Medical and Health Administration Policy

iii. National Population Policy

94. The Group feels that its Report should be very widely circulated and every State/Union Territory may, within the overall recommended approaches, draw up detailed schemes and programmes, suiting its requirements. It is also recommended that the Health Ministry, establish mechanisms to monitor progress regularly and consider such modifications in the approach to meet the other problems. as may be necessary.

ANNEXURE I

(Ref.: Paragraph 1)

MEMBERS OF THE WORKING GROUP ON HEALTH

1.	Shri Kripa Narain, Secetary, Ministry of Health and Family Welfare, New Delhi & President, All India Institute of Medical Sciences	Chairman
2.	Dr. V. Ramalingaswamy, Director General, Indian Council of Medical Research, New Delhi	Member
3.	Dr. N.H. Antia, Foundation for Research in Community Health, Bombay	Member
4.	Dr. K.S. Sanjivi, Vice-Chairman, MAC Institute of Community Health, Adyar, Madras	Member
5.	Dr. R.K. Menda, President, Indian Medical Association	Member
6.	Smt. Serla Grewal, Additional Secretary and Commissioner (FW), Ministry of Health and Family Welfare, New Delhi	Member
7.	Smt. P.P. Trivedi, Adviser (State Plans), Planning Commission, New Delhi	Member
8.	Dr. B. Sankaran, Director General of Health Services, Ministry of Health and Family Welfare, New Delhi	Member
9.	Shri C.V.S. Mani, Additional Secretary, Ministry of Health and Family Welfare, New Delhi	Member
10.	Representative of the Ministry of Social Welfare	Member
11.	Representative of the Ministry of Education	Member
12.	Representative of the Ministry of Works and Housing	Member
13.	Representative of the Ministry of Rural Reconstruction	Member
14.	Development Commissioner, Drugs, Ministry of Petroleum and Chemicals, New Delhi	Member
15.	Secretary (Health), Government of Maharashtra	Member

16.	Secretary (Health), Government of Kerala	Member
17.	Director, Health Services, Uttar Pradesh	Member
18.	Director, Health Services, Haryana	Member
19.	Director, Medical Education, Gujarat	Member
20.	Director, Medical Education, Karnataka	Member
21.	Shri T.V. Antony, Joint Secretary, Ministry of Health and Family Welfare, New Delhi	Member
22.	Shri N.N. Vohra, Joint Secretary, Ministry of Health and Family Welfare, New Delhi	Member
23.	Shri R. Natarajan, Joint Secretary, Ministry of Health and Family Welfare, New Delhi	Member
24.	Shri R.R. Gupta, Joint Secretary, Ministry of Health and Family Welfare, New Delhi	Member
25.	Director, All India Institute of Medical Sciences, New Delhi	Member
26.	Director, National Institute of Health and Family Welfare, New Delhi	Member
27.	Director, National Institute of Communicable Diseases, Delhi	Member
28.	Director, National Malaria Eradication Programme, 22, Sham Nath Marg, Delhi	Member
29.	Deputy Director General (Planning), Directorate General of Health Services, New Delhi	Member
30.	Deputy Director General (Rural Health), Directorate General of Health Services, New Delhi	Member
31.	Drugs Controller of India, Directorate General of Health Services, New Delhi	Member
32.	Shri R.K. Singhal, Joint Secretary, Ministry of Health and Family Welfare, New Delhi	Convenor & Member-Secretary

ANNEXURE II

(Ref.: Paragraph 6)

HEALTH INDICATORS/TARGETS, PHASED PLAN-WISE, FOR ACHIEVEMENT BY 2000 A.D.

Sr. No.	Index	Present level	Target 1985	Target 1990	Target 2000	Remarks
1	2	3	4	5	6	7
1.	Infant mortality (per 1000 live birth)	Rural 136 (1978)	122	-	-	Based on Survey of Infant and Child Mortality 1979, Registrar General, India. It is assumed that rural rates would decline by 2 points annually and urban rates by 1.5 points. It is assumed that a larger reduction in neo-natal mortality would be possible through MCH services while post-natal mortality reduction, which is responsive to socio-economic development, would be slower.
		Urban 70 (1978)	60	-	-	
		Total 125 (1978)	106	87	below 60	
		RURAL				
		Neo-natal 76 (1978)	88			
		Post-Neo-Natal 60 (1978)	56			
	Perinatal mortality	60-109	-	-	30-35	Estimated from hospital data and hence not fully representative. The targets for 2000 A.D. are the levels in advanced countries.
2.	Crude death rate (per 1000 population)	14.1 (1978)	11.6	10.4	9.0	Based on Expert Committee on Population Projections.
3.	Preschool (1-5 yrs.) mortality	35-40	25-30	15-20	10	
4.	Maternal Mortality rate	4.8 (1976)	3-4	2-3	below 2	Based on the Cause of Death Survey, 1976, Registrar General, India.
5.	Life expectancy at birth:					
	Male	52.6	55.1	57.6	64 yrs.	Based on Expert Committee on Population Projections. It is implied that expectation of life would increase annually by 0.5 years according to UN estimates for developing countries.
	Female	51.6	54.3	57.1	64 yrs.	

1	2	3	4	5	6	7
6.	Birth weight below 2500 gms. (percentage)	30%	25%	18%	10%	It is assumed that the Nutrition component of the M.N.P. particularly the supplementary feeding of pregnant women would be vigorously implemented. It is also expected that socio-economic development would progressively improve the nutritional status of pregnant women.
7.	Crude birth rate (per 1000 population)	33.2 (1978)	29.5	27.0	21.0	Based on Expert Committee on Population Projections.
8.	Effective couple protection (percentage of couple in the reproductive age group protected by a modern method)	22.8 (1979-80)	32.0	42.0	60.0	Based on the Working Group on Population Policy which envisages an increase in couple protection by 2 points annually.
9.	Net Reproduction Rate (NRR)	1.51 (1980-81)	1.34	1.17	1.00	Based on the Working Group on Population Policy.
10.	Natural Growth Rate	1.91 (1978)	1.79	1.66	1.20	Based on Sample Registration System of R.G. and Expert Committee on Population Projections.
11.	Family Size	4.3 (1979)	3.8	-	2.3	Based on Working Group on Population Policy and the level of vital rates.
12.	Mean age at first marriage (female)	17.2 (1971)	18.0	-	-	It is assumed that the law regarding minimum age at marriage should be vigorously implemented so that mostly females marry after attaining the age of 18 years.
13.	% pregnant mothers receiving ante-natal care	40-50%	50-60	60-75	100%	
14.	% of deliveries by trained birth attendants	10-15%	50%	80%	100%	It is assumed that sub-centre coverage would reach 70% by 1983 and the *Dais* training programme would be fully implemented.

1	2	3	4	5	6	7
15.	Immunisation Status (%age Coverage)	(Prior to 1980-81)				
	TT (for pregnant women)	20	60	100	100*	*Booster dose only
	TT (for school going children)					
	10 years	-	40	100*	100*	
	16 years	-	70	100*	100*	
	DPT (Infants)	25	70	85**	85**	**Immunisation coverage of 85% will achieve the objective of reducing the morbidity; however immunisation services are to be available for 100% of eligible population.
	Polio (Infants)	5	25	40	85**	
	BCG (Infants)	65	70	80	85**	
	DT (New entrants of school 5-6 years)	20	80	85**	85**	
	Anti-Typhoid (New entrants of school 5-6 years)	2	70	85**	85**	
16.	% Coverage by Vit. 'A' prophylaxis (0-5 years)	25%	50%	Maintenance		
17.	% Coverage of nutritional supplement (iron & folic acid)					
	(a) Expectant mother	25-30 (1978-79)	50%	Maintenance		It is assumed that those not covered by the official programme would have nutritional supplement through their own resources.
	(b) Children upto 12 years	10%	50%	Maintenance		
18.	% Coverage of one new PHC for 30,000 population.	-	30% (1988)	60%	100% (1995)	
	% Coverage of one Sub-Centre for 5,000 population	41%	71%	100%	100%	
19.	% Population with protected water supply Rural	30	60	100	100	These indicators are as discussed in the Working Group meeting held on 31st July, 1980.
	Urban	80	90	100	100	
20.	% Population with sound human excreta disposal					
	Rural	2	10	25	100	These indicators are as discussed in the Working Group meeting held on 31st July, 1980
	Urban (including sewerage)	34	60	80	100	

1	2	3	4	5	6	7
21.	Malaria					
	(a) A.P.I.	4.6	2.7	1.9	Below 0.5	
	(b) Deaths recorded and verified	300	Nil	Nil	Nil	
22.	Leprosy					
	(a) Total number of cases detected as percentage of total estimated case load	60%	90%	100%	100%	
	(b) Disease arrested case out of (a)	20%	40%	60%	80%	
23.	Tuberculosis					
	(a) Total number of cases detected as percentage of total estimated case load	30%	50%	70%	100%	
	(b) Disease arrested cases	60%	75%	95%	95%	
24.	Blindness					
	Percentage of Blindness	14%	1%	0.7%	0.3%	
25.	Guinea-worm Infection (% reduction)	...	50%	100%	Maintained	Health Education case detection and treatment.
26.	Goitre (% reduction)	...	50%	75%	above 95%	Survey, supply of iodised salt to the Goitre prone areas.
27.	Scabies - reduction (population coverage)	...	40%	75%	above 95%	Treatment of cases and health education.

1	2	3	4	5	6	7
28.	Diarrhoeal Diseases (reduction in mortality)	...	35%	75%	above 95%	Early case detection ORS, training in ORS and health education.
29.	Filaria (Number of Micro Filaria Carriers)	35 million	25 million	15 million	2.5 million	
30.	Respiratory Diseases other than T.B. (% reduction)	25%	70%	Main-tained	Maintained	
31.	Dental Health (% population coverage)	...	30%	60%	above 95%	Establishment of dental clinics, dental colleges, school dental services, health education.
32.	Mental Health (population coverage)	...	20%	50%	75%	Case detection and treatment.
33.	School Health (population coverage)	...	50%	75%	100%	

ANNEXURE III

(Ref.: Paragraph 7)

RECOMMENDED STAFFING PATTERN FOR THE PROPOSED COMMUNITY HEALTH CENTRE

1.	Qualified/Trained Surgeon	...	...	1
2.	Qualified/Trained Gynaecologist	...	...	1
3.	Qualified/Trained Physician	...	...	1
4.	Qualified/Trained Paediatrician	...	...	1
5.	General Duty Medical Officer (Trained in Public Health)	...	...	1
6.	General Duty Medical Officer (Trained in Anaesthesia)	...	...	1
7.	General Duty Medical Officer (from one of the traditional systems of medicine)	...	...	1
8.	Nurses	...	...	8 (one of the nurses should also provide preventive dental health)
9.	Pharmacist	...	...	2
10.	Lab. Technician	...	...	2
11.	X-ray Technician	...	...	1
12.	Ward attendant (female)	...	...	4
13.	Ward attendant (Male)	...	...	4
14.	Sweeperesses	...	...	4
15.	Sweepers	...	...	4
16.	Driver	...	...	1
17.	Cashier (UDC)	...	...	1
18.	U.D.C.	...	...	1
19.	L.D.C. Typist	...	...	1
20.	Extension Educator	...	...	1
21.	Ophthalmic Assistant	...	...	1
22.	Statistical Assistant	...	...	1
23.	Peons	...	...	2
24.	Chowkidars	...	...	4
25.	No. of Beds	...	...	30

ANNEXURE IV

(Ref.: Paragraph 10)

HEALTH SERVICES ORGANISATION (PHASED PLAN-WISE) - PERSPECTIVE 2000 A.D.

	Unit	Norms	In position as on 1.4.80	Plan period 1980-85			Plan period 1985-90			Plan period 1990-95		Plan 1995-2000 AD
				Total requirement	To be established during the Plan	Likely position on 31.3.85	Total requirement	To be added during the Plan	Likely position on 31.3.90	Total requirement by 2000 A.D.	To be added during the Plan	
1.	Community Health Volunteers	1 for 1000 per village 1:500 in tribal areas.	1.4 lakh	6.3 lakh	4.4 lakh	5.8 lakh	651,500	71,500	651,500	738,000	86,500	Backlog
2.	Sub-Centres	1:5000 1:2500 in tribal areas	50,000	122,150	40,000	90,000	130,300	40,000	130,000	160,800	30,800	Backlog
3.	Primary Health Centres	1:30,000	-	18,558	6,000**	6,000	19,887	6,000**	12,000	22,470	10,470	Backlog
4.	Community Health Centres	1:100,000 or 1 per C.D. Block	430***	5,500	1,800*	2,230	5,500	2,250*	4,480	5,500	1,020*	Backlog

*The existing PHCs will be converted into CHC by upgrading the same.
**By upgrading existing dispensaries.
***Upgraded PHCs out of existing 5,500 PHCs.

ANNEXURE V

(Ref.: Paragraph 11)

PROPOSED OUTLAY UNDER MINIMUM NEEDS PROGRAMME FOR SIXTH FIVE YEAR PLAN 1980-85

S.No.	Units	Number of Units	Per Unit Cost			Proposed outlay (in crores)			Total for 1980-85 (Rs. in crores)	Estimates of outlay 1985-90	Estimates of outlay 1995-2000
			Construction Rs.	Equipment Rs.	Recurring Rs.	Construction	Equipment	Recurring			
1	2	3	4	5	6	7	8	9	10	11	12
1.	Community Health Volunteers	4.4 lakh	-	Rs.68,400 per PHC	1.2 lakh per PHC	-	24.88	230.12	255.00		
2.	Sub-Centres										
	i. Backlog of construction	23,300	40,000	-	-	93.20	-	-	93.20		
	ii. Construction of accommodation for Male MPW	50,000	30,000	-	-	150.00	-	-	150.00		
	iii. Accommodation for Health Assistants	12,500	50,000	-	-	62.50	-	-	62.50		
	iv. Establishment of new Sub-Centres	40,000	70,000	5,000	10,000	280.00	20.00	80.00	380.00		
	v. H.A's Accommodation in new Sub-Centres	10,000	50,000	-	-	50.00	-	-	50.00		
3.	Backlog of construction of existing PHCs										
	i. Backlog of construction of PHC buildings	1,887	2,00,000	-	-	37.14	-	-	37.14		
	ii. Backlog of construction of staff quarters	3,230	1,50,000	48.45	-	48.45	-	-	48.45		
4.	Upgrading of PHC's backlog	430	5,00,000	5,00,000	3,00,000	21.50	21.50	38.70	81.70		

1	2	3	4	5	6	7	8	9	10	11	12
5.	Conversion of existing PHCs into Community Health Centres	1,800	20 lakh	10 lakh	5,00,000	360.00	180.00	180.00	720.00		
6.	Training of C.H. Officers	6,000	5 lakh per centre	-	10,000	7.50	-	6.00	13.50		
7.	Strengthening/ creating training facilities for specialists, technicians, pharmacists and other paramedicals	-	-	-	-	-	-	-	50.00		
8.	MPW Scheme	-	-	-	-	6.00	15.75	41.63	63.38		
9.	Health Posts in urban slums	5,000	-	5,000	10,000	-	2.50	10.00	12.50		
10.	Upgradation of dispensaries into PHCs	6,000	1,50,000	25,000	50,000	90.00	25.00	60.00	165.00		
11.	Employment of MPW (Male)	10,000	-	-	6,000	-	-	12.00	12.00		
12.	Employment of Health Assistants (Male)	1,500	-	-	8,000	-	-	2.40	2.40		
						1,206.29	279.63	660.85	1,996.77		
					Less Rs.100 crores cost of equipment and running cost of new Sub-Centres shown under F.W. Budget.				100.00		
									Rs.1,896.77		

ANNEXURE VI

(Ref.: Paragraph 20)

HEALTH MANPOWER REQUIREMENT AND AVAILABLE TRAINING CAPACITY

Sr. No.	Category	In position on 1.4.80	Additional requirement 1980-85	Training capacity per year	Net availability during 1981-85	Additional requirement 1985-90	Additional requirement 1990-95
1.	Community Health Volunteers	1,40,000	4,40,000	Available for requirement.		71,500	86,500
2.	Female M.P. Workers	50,000	51,000	13,000	52,000	50,000	38,500
3.	Male M.P. Workers	80,000	11,000**	Nil	Nil	50,000	38,500
4.	Female Health Assistants	11,000	11,000	3,600	14,400	10,000	7,700
5.	Male Health Assistants	21,000	1,500**	Nil	Nil	10,000	7,700
6.	Pharmacists	20,500	2,230	3,500	14,000	10,250	14,000
7.	Nurses	-	20,642	Would be available		18,000	18,080
8.	X-Ray Technicians	-	2,230	180*	720*	2,250	2,260
9.	Lab. Technicians	5,500	8,230	1,300*	5,200*	7,250	8,000
10.	Ophth. Assistants	500*	5,200	2,000	5,200	1,340	-
11.	Doctors trained in*						
	a. Surgery	-	1,800	Nil	-	2,250	2,260
	b. Gynaecology	-	1,800	Nil	-	2,250	2,260
	c. Medicine	-	1,800	Nil	-	2,250	2,260
	d. Paediatrics	-	1,800	Nil	-	2,250	2,260
	e. Public Health	-	1,800	Nil	-	2,250	2,260
	f. Anaesthesia	-	1,800	Nil	-	2,250	2,260
12.	Training of doctors of traditional system in Public Health	-	10,000	Nil	-	5,000	3,000
13.	Community Health Officers*	-	6,000	Nil	-	6,000	6,558

*Training capacity would require to be augmented.
**Training facilities would require to be created.

ANNEXURE VII

(Ref.: Paragraph 39)

*TEN MAJOR CAUSES OF DEATHS IN INFANTS AND CHILDREN (1-5 years)

Infants			Children (1-5 years)		
Sr. No.	Disease	% of deaths due to	Sr. No.	Disease	% of deaths due to
1.	Tetanus	15.2	1.	Typhoid	11.0
2.	Pre-maturity	7.9	2.	Pneumonia	8.4
3.	Pneumonia	6.8	3.	Dysentery	7.0
4.	Dysentery	6.1	4.	Jaundice	6.2
5.	Influenza	4.9	5.	Diarrhoea	5.8
6.	Malaria and other fevers	4.7	6.	Malaria and other fevers	5.3
7.	Typhoid	3.8	7.	Influenza	5.2
8.	Other Respiratory Diseases	2.6	8.	Other Respiratory Diseases	2.3
9.	Diarrhoea	1.6	9.	Gastro-enteritis	1.7
10.	Gastro-enteritis	1.3	10.	Tetanus	1.4

*Survey of Infant and Child mortality 1979,
Registrar General of India

ANNEXURE VIII

(Ref.: Paragraph 91)

STATEMENT SHOWING THE FINANCIAL INPUTS UNDER THE VARIOUS FIVE YEAR PLANS

(Rs. in crores)

Sr. No.	Plan Period	Expenditure Incurred			Percentage of expenditure of			Per Capita expenditure(on mid-Plan Year Population Figures)		
		Overall Public Sector	Social Services Sector	Health Sector	Health Sector to Public Sector	Health Sector to Social Services Sector	Social Services Sector to Public Sector	Public Sector	Social Services Sector	Health
1.	First Plan (1951-56)	1,960	412	98	5.0	23.8	21.0	52.41	11.02	2.62
2.	Second Plan (1956-61)	4,672	729	216	4.6	29.6	15.6	113.39	17.69	5.24
3.	Third Plan (1961-66)	8,577	1,296	226	2.6	17.4	15.1	187.24	28.29	4.93
4.	Annual Plan (1966-69)	6,757	859	140	2.1	16.3	12.7	132.24	16.81	2.74
5.	Fourth Plan (1969-74)	15,902	2,507	436	2.7	17.4	15.8	290.69	45.83	7.97
6.	Fifth Plan* (1974-79)	39,322	5,183	682	1.7	13.2	13.2	631.99	83.34	10.97
7.	1978-83 *Outlay	71,000	9,355	1,330	1.8	14.0	13.0			

A meeting of the Health Experts, Research Scientists, Medical Educationists, Social Scientists, Health Administrators and Representatives of Planning Commission, related Ministries/Departments of the Central Government and State Governments/ Union Territories and Voluntary Organisations was called by Shri Kripa Narain, Secretary, Ministry of Health and Family Welfare on 11th and 12th February, 1980 to discuss and evolve the framework of strategies for achieving the objective of Health for All by 2000 A.D. A list of participants at this meeting is given at page 43. The participants after expressing their views requested the Chairman to appoint five Sub-Groups to formulate the strategies in the light of the views expressed by the participants. It was further suggested that the five working groups should cover the topics of:

i. (a) Meaning of Health for All in the background of India's Health Needs; (b) Indices to be achieved by 2000 A.D.; (c) Plan-wise planning of indices; and (d) Strategies to be followed to achieve Health for All by 2000 A.D.

ii. Inter-Sectoral Coordination

iii. Community Participation

iv. Role of the Voluntary Organisations

v. Health Services Organisation

The reports of the Sub-Groups are annexed.

LIST OF PARTICIPANTS

(Ref.: Paragraph 2)

List of the participants at the Meeting held under the Chairmanship of Shri Kripa Narain, Secretary, Ministry of Health and Family Welfare on 11th-12th February, 1980, in Nirman Bhavan, to discuss and evolve framework of strategies for achieving the objective of Health for All by 2000 A.D.

1.	Shri Kripa Narain	Secretary, Ministry of Health and Family Welfare, New Delhi
2.	Dr. B.N. Sinha	President, Medical Council of India, 9, A.P. Sen Road, Lucknow
3.	Dr. V. Ramalingaswamy	Director General, Indian Council of Medical Research, New Delhi
4.	Prof. J.P. Naik	Indian Institute of Education, Pune
5.	Dr. R.S. Arole	Director, Comprehensive Rural Health Project, Jamkhed (Maharashtra)
6.	Dr. Malcolm Adeseshia	Director, Institute of Development, Madras
7.	Dr. K.S. Sanjivi	Ex-UNICEF Consultant on Primary Health Care, 11 Link Street, C.I.P. Colony, Madras
8.	Dr. K.N. Udupa	Director, Institute of Medical Sciences, Banaras Hindu University, Varanasi
9.	Dr. K.N. Rao	Chairman, Health Association of India, D-57 Naraina, New Delhi
10.	Dr. N. Jungalwalla	Controller of Examinations, National Board of Examinations, New Delhi
11.	Dr. N.H. Antia	Foundation for Research in Community, Bombay
12.	Dr.(Mrs.) L.V. Phatak	Director, Birla Institute of Medical Research, Gwalior
	Dr.(Mrs.) Banoo Coyaji	Director, K.E.M. Hospital, Pune
	Dr. H.W. Butt	Director, Indo-Dutch Project for Welfare, Hyderabad

15.	Dr. M.G. Garg	Indian Medical Association, New Delhi
16.	Dr. D. Banerjee	Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi
17.	Dr. B.K. Anand	President, National Academy of Medical Sciences, New Delhi
18.	Dr. S. Rohatgi	Pharmacist, Post Box No. 227, Kanpur, U.P.
19.	Dr. Lalit P. Aggarwal	Director, All India Institute of Medical Sciences, New Delhi
20.	Kaviraj Nanak Chand Sharma	Director, Kayamaya Ayurvedic Pharmaceutical Works Pvt. Ltd., Delhi
21.	Dr. P.C. Mehta	Homoeopathic Consultant, 34-B, Pusa Road, New Delhi
22.	Dr.(Mrs.) Kamakshi Sundaram	Managing Trustee, Matree Trust, Tamil Nadu
23.	Dr. L. Ramachandran	Director, Gandhigram Institute of Rural Health and Family Planning, P.O. Ambathurai, Madurai Dist.
24.	Shri J.S. Bali	Consultant, Voluntary Health Association of India, C-66, Defence Colony, New Delhi
25.	Dr. Dalip Mukharji	Director, Rural Unit for Health and Social Affairs, Melkavanur, Tamil Nadu
26.	Dr. B.N. Tandon	Professor, All India Institute of Medical Sciences, New Delhi
27.	Dr. Vijya Kumar	Head, Community Medicine, Post-Graduate Institute of Medical Education and Research, Chandigarh
28.	Dr. G.S. Mutalik	Director, Comprehensive Health Services, WHO-SEARO, New Delhi
29.	Dr. D.A.W Nugent	WHO Programme Coordinator in India
30.	Dr. Sombhong Kutranon	Regional Adviser on Community Health, WHO
31.	Dr. J.P. Greaves	Senior Programme Officer, UNICEF, New Delhi
32.	Shri M.K. Mukherjee	Secretary, Ministry of Works and Housing, New Delhi

33.	Mrs. P.P. Trivedi	Adviser, Planning Commission, New Delhi
34.	Shri P.K. Chatterjee	Adviser (PHEE), CPHEEO, Ministry of Works and Housing, New Delhi
35.	Shri M.M. Rajendran	Jt. Secretary, Ministry of Social Welfare, New Delhi
36.	Shri B.K. Sharma	Jt. Secretary, Ministry of Rural Reconstruction, New Delhi
37.	Shri N.P. Nawani	Director (CD), Ministry of Social Welfare, New Delhi
38.	Dr. Ahmed Masood	Deputy Development Commissioner (Drugs), Department of Chemical and Fertilizer
39.	Shri M.R. Parthasarathy	Dy. Adviser (PHE), CPHEEO, Ministry of Works and Housing, New Delhi
40.	Shri P.H.A. Sundram	Dy. Secretary, Ministry of Works and Housing, New Delhi
41.	Dr. N.K. Sinha	Dy. Adviser Health, Planning Commission, New Delhi
42.	Shri P. Murari	Health Commissioner, Madras
43.	Dr. S.N. Gupta	Special Secretary, Health, U.P., Lucknow
44.	Dr. Y.P. Rudrappa	Director, Medical Education, Bangalore
45.	Dr. H.N. Patel	Director of Health and Medical Services, Ahmedabad
Ministry of Health and Family Welfare and DGHS		
46.	Smt. S. Grewal	Additional Secretary and Commissioner (FW)
47.	Dr. B. Sankaran	Director General of Health Services
48.	Dr. I.D. Bajaj	Addl. Director General of Health Services
49.	Shri R.K. Singhal	Jt. Secretary
50.	Shri R. Natarajan	Jt. Secretary
51.	Shri R.R. Gupta	Jt. Secretary
52.	Shri T.V. Antony	Jt. Secretary

53.	Shri V.N. Kakar	Chief Media
54.	Dr. S. Pattnayak	Director, N.M.E.P.
55.	Dr. Ranjit Sen	Dy. Director General of Health Services
56.	Dr. M.D. Saigal	Dy. Director General of Health Services
57.	Dr.(Miss) E.V. Sebastian	Dy. Commissioner (MCW)
58.	Dr. N.S. Deodhar	Director, All India Institute of Hygiene and Public Health, Calcutta
59.	Dr. B.N.M. Barua	Adviser (TB)
60.	Dr. Mahendra Dutta	Director, Central Bureau of Health Intelligence, New Delhi
61.	Dr. V.K. Rambhadran	Director, Evaluation & Intelligence
62.	Dr. P.N.V. Kurup	Adviser (ISM)
63.	Dr. K.C. Das	ADG (Leprosy)
64.	Dr. P.C. Sen	Adviser (Nutrition)
65.	Dr. B.P. Bose	ADG (HA)
66.	Dr.(Mrs.) M.H. Bhagat	AC (Trg.)
67.	Dr. Sarah Israel	OSD (Trg)
68.	Dr.(Mrs.) K. Kathpalia	DAC (Trg)
69.	Mrs. P.K. Karthiyani	Nursing Adviser
70.	Dr. K.B. Banerjee	DADG (CH)
71.	Dr. Mahendra Singh	MO (RH)
72.	Shri V.K. Tyagi	D.P.I.O.
73.	Shri Sarweshwar Jha	US (RHS)
74.	Shri N.N. Vohra	Joint Secretary /- Convenor

REPORT OF THE SUB-GROUP ON

(a) MEANING OF HEALTH FOR ALL IN THE BACKGROUND OF INDIA'S HEALTH NEEDS;

(b) INDICES TO BE ACHIEVED BY 2000 A.D.;

(c) PLAN-WISE PLANNING OF INDICES; AND

(d) STRATEGIES TO BE FOLLOWED TO ACHIEVE HEALTH FOR ALL BY 2000 A.D.

1.0 *Introduction*

A list of the members and special invitees who attended the meeting of Group 1 held on the 28th March, 1980 at ICMR Headquarters, New Delhi is at Annexure I. The terms of reference of the Group included:

i. meaning of 'Health for All' in the background of India's health needs'

ii. indices (health indicators) to be achieved by 2000 A.D.;

iii. plan-wise phasing of indices; and

iv. strategies and sub-strategies to be followed.

2.0 *Preamble*

2.1 Support of Health-related Sectors

An acceptable level of 'Health for All by the year 2000 A.D.' can only be achieved through the coordinated effort of the health sector and relevant activities of other social and economic development (health-related) sectors. Since health development both contributes to and results from social and economic development, health policies ideally should form part of overall development policy, thus reflecting the social and economic goals of the Government and the people. In this way strategies for health and social and economic sectors will be mutually supportive and together contribute to the ultimate goals of the society.

2.2 National Commitment

National political commitment is essential to strengthen the development process needed to attain 'Health for All' as well as to obtain needed financial resources. This will require in the first instance a political decision by the Central and State Governments, and, subsequently, active involvement of all levels, sectors and interests in the development of the national policies, strategies and plans of action.

2.3 Community Participation

Notwithstanding the overall responsibility of the Central and State

Governments for the health of the people, community participation is necessary to realise the goal of 'Health for All' so that individuals, families and communities assume greater responsibility for their own health and welfare, including self-care, and more towards achieving self-reliance. Appropriate ways of promoting such individual and collective participation of the people in planning and implementation of activities for their health and related social development will therefore have to be devised.

2.4 Primary Health Care Approach

To achieve the goal of 'Health for All by the year 2000 A.D.' the primary health care approach is essential; it will require the support of the health system of which it is an integral part and the central function and main agent for delivering health care; it will also require the support of other social and economic sectors concerned. Health system support includes facilities for consultation on health problems, referral of patients to local and more specialised health institutions, provision of supportive supervision and guidance, logistic support and supplies. As for the support of other sectors, particular emphasis will have to be laid on such sector as education, food and agriculture, social welfare, animal husbandry, housing and public works, rural reconstruction etc. Health activities should be undertaken concurrently with measures such as those for increase in production and employment; equitable distribution of personal income; improvement of nutrition, particularly of children and mothers; improvement of environmental sanitation; anti-poverty measures; etc.

2.5 Focus on the Preventive and Promotive Aspects of Health

Since the prevailing health problems in the country are associated with high prevalence of communicable diseases, malnutrition and poor environmental sanitation, the possible health actions that should be undertaken through the least sophisticated primary health care have to emphasise prevention and promotion of health, providing only minimal essential medical care and 'first-aid' for common ailments and injuries.

3.0 *Meaning (Content) of 'Health for All'*

In the content of socio-economic and health situation of our people and the status of health system in the country, 'Health for All by the year 2000 A.D.' should include provision of at least a minimum package of health care services to all the segments of the population, giving priority to the underprivileged sections of the society. The package should include:

1. health education concerning prevailing health problems and the methods of preventing and controlling them;

2. activities directed towards the promotion of food supply and the improvement of nutritional status;

3. provision of protected water supply and sanitary disposal of excreta;

4. provision of appropriate health care to vulnerable groups of population *i.e.* children and pregnant women, including family planning;

5. prevention and control of prevalent endemic communicable and non-communicable diseases:

   - by immunisation (EPI target diseases)

   - through appropriate measures (Leprosy, Tuberculosis, Goitre and curable blindness)

   - interruption of transmismission of vector-borne diseases (Malaria, Filaria and Kala-azar)

   - reduction of diarrhoeal diseases mortality through wide application of oral rehydration therapy and of intestinal parasitic infestation morbidity through application of appropriate community measures; and

6. access to essential medical care for all people for common ailments and injuries, including provision of simple drugs.

4.0 *Selection of Indicators*

4.1 Utility of Indicators

Indicators of health are needed to monitor the progress of implementation of health and related socio-economic services as well as to assess their impact on health. Both the organisational levels *i.e.* the policy level and the managerial and technical levels have to be involved in monitoring of implementation and evaluation of impact. The policy-makers need to know if any revision of policy, strategy or plans of action are required, and the managers need to know if the programmes formulated and services designed are adequate to reach the goal. It should, however, be realised that indicators are not synonymous with targets but are measures of the extent to which the targets are being reached.

4.2 Types of Indicators Needed

Broadly, two types of indicators are needed - those that measures health status and related quality of life - health impact indicators, and those that measures the provision of health care services - health service indicators. The health impact indicators include (i) indicators of morbidity and mortality including life expectancy, (ii) indicators of growth and development and nutrition, (iii) indicators relating to socio-economic factors that affect health directly or indirectly such as of environmental conditions, educational levels, food consumption, etc. The health service indicators would monitor the attainment of objectives and targets that have been set while formulating health programmes and designing health services such as immunisation status, provision of protected water supply and sanitation, eligible couples covered under family planning etc. They should also cover the extent of coverage of the services of the community.

4.3 Problems of Data Collection

There are problems in compiling the indices since the ability of the health information system to gather data is restricted in our country. It is accepted that as health services improve *paripassu* the information system would also improve and therefore more indicators could be developed in course of time. At present a pragmatic approach in laying down the health indicators to measure the achievement of 'Health for All by the year 2000 A.D.' is indicated; a minimal number of highly selective but intensely practical indicators in the existing constraints of information collection could serve to begin with and additional indicators added when feasible. Efforts may be made to arouse interest in specialised institutions to undertake analytical indepth longitudinal studies on a sample basis in order to generate reliable estimates on wider parameters of health.

4.4 Other Criteria of Selection of Indicators

A few other considerations in the selection of indicators are:

1. their ability to assess specifically what is happening to the weaker sections of population and how the chosen interventions are making an impact;

2. national averages have limited significance and therefore, disaggregated data on at least a few of the indicators to provide State and preferably district level changes would be useful;

3. rural-urban and age-sex differentials are needed to measure the impact of rural health service and special services for vulnerable groups;

4. minimum number of indicators commensurate with the national plans of action could suffice to begin with provided they incorporate parameters for essential health programmes and services;

5. need to gather data through sample surveys on out-reach indicators to assess the extension and coverage of services;

6. morbidity indicators have limitations for use at present because of paucity of baseline and lack of mechanism for obtaining such data (except to some extent for Malaria and Tuberculosis), and urgent efforts needed to develop such data for important communicable and non-communicable endemic diseases through sample survey techniques.

4.5 Recommended National Health Indicators

Considering the limited ability of existing health information system *vis-a-vis* the need to monitor implementation of 'Health for All' activities as well as to assess their impact, a minimal list of health indicators together with those recommended to be developed through samples studies is given in Annexure II. This minimal list includes both health impact indices (negative-mortality and morbidity, and positive indicators) as well as health service

indices (of health activities, health resources including facilities), and indicators of physical quality of life. The indices have been selected because of their direct strong relationship to health. Other indices having significant relationship to health that have not been listed, are being generated by other sectors and information on these have to be collected from relevant sources for developing an overall perspective of health. Some examples of these indices are measurement of income, employment, literacy, food production and consumption etc. The indices of health service listed are by no means adequate to provide a functional index of health care system. This would only be possible through sample studies carried out by selected research institutes. A network of such institutes would provide the resource base for the programme development of a National Health Information System. It would also be necessary to develop minimum indicators of community participation, and institutes with expertise in operational research in social sciences should investigate this area immediately. Finally, ways and means to measure the total financial inputs in providing health care services to the community inclusive of private inputs have to be also explored.

5.0 *Targets and Phasing*

With the available technology (provided needed resources and political commitment are forthcoming), the highlights of targets that can be achieved by the year 2000 A.D. are:

Types of Health Status Index		NATIONAL AVERAGES		
		Present	Mid-point (1990)	Year 2000 A.D
1. Crude Birth Rate		33.2	27.0	21.0
2. Crude Death Rate		14.1	10.4	9
3. Infant Mortality Rate (Rural)		130-135	80-90	65
(Urban)		80-85	60-65	50
4. Pre-school (below 5 years) Mortality (Rural)		35-40	20-65	10
(Urban)		20-25	15	5
5. Life Expectancy at Birth	M	52.6 years	58.0 M	64 yrs.
	F	51.6 years	57.7 F	64 yrs.
6. Maternal Mortality Rate (per thousand live births)	R	6-8	-	Below 2
7. Net Reproduction Rate		1.67	-	1.00

Details of other possible indicators are given in Annexure III.

6.0 *Strategies and Sub-strategies*

6.1 Continuing Political Commitment

The attainment of the objective of 'Health for All by the year 2000 A.D.' with primary health care as the key approach requires first and foremost the securing of firm continuing political support from the top decision-making levels, if necessary by framing of a constitutional mandate, not merely to a declaration of national health policy (as an integral part of national socio-economic development) but also to its translation into a national action plan.

6.2 Community Participation

Equally important to achieve a breakthrough is the full and effective participation of the community on a continuing basis in all developmental activities related to 'Health for All' objectives at each level, together with mobilisation of community resources.

6.3 Health Planning Development

A logical consequence will be the activation, and if needed strengthening, of the existing national health planning mechanism to review and reorient perspective health development plans, both intra-sectoral and inter-sectoral, in the light of 'Health for All by the year 2000 A.D.' requirements including identification of overall manpower requirement and its development, the strengthening of infrastructure, additional resources required etc.

6.4 Setting of Cabinet Sub-committee and Implementation Committees

Implementation of the plans would be greatly accelerated by the setting up of a Cabinet Sub-Committee on primary health care and also multi-sectoral Implementation Committee for 'Health for All' with adequate community representation at Central, State and District level with well defined terms of reference to monitor the progress and ensure inter-sectoral cooperation.

6.5 Health Service Research

While enough is already known about the principles of primary health care to improve and expand its implementation immediately, several new problems relating to operation, control and evaluation are bound to emerge as its wide implementation under varying local situation proceeds. For resolving such problems, it is essential to build into the programme from the outset the element of organised health service research. Educational and research institutions in close collaboration with the health service organisation would need to develop units and field areas that operate in parallel with the general implementation process to undertake operational studies, and also encourage evaluation and feedback from health service organisation for early identification of problems. Institutes in different parts of the country should be selected on the basis of their demonstrated interest and competence for health care delivery research. These institutions will also promote development of a wider spectrum of indicators and design and carry out studies on a sampling

basis to fill some of the gaps in the measurement of health services that the present information system cannot provide. These carefully chosen and designated institutes will constitute a valuable reserve for the nation.

6.6 Appropriate Technology

Since the use of appropriate technology is a *sine-qua-non* for achievement of 'Health for All by the year 2000 A.D.' identification, development adaptation and implementation of appropriate technologies for health on a continuing basis is essential. It would be necessary to establish focal points/ groups to provide budgetary, administrative and technical support for continued development of appropriate technology.

6.7 Other Factors

Other factors to be considered include:

1. attitudinal changes to the new perspective at all levels of the health care system;

2. conceptual change from a curative medicine to participatory, preventive and promotive health services again at all levels of the Health Care System;

3. reorientation of organisational structure at State, District and Block levels and of their procedures including delegation of authority, commensurate with the responsibility of decision-making and implementation and to provide for their accountability;

4. mobilisation of social resources (non-governmental organisation);

5. harnessing the services of traditional practitioners;

6. continuing education and supportive supervision of primary health centre physicians (particularly to enhance their managerial and epidemiological component) with adequate back-up of referral systems;

7. delivery of primary health care services in the form of package including MCH, nutrition and sanitation;

8. micro-planning at village level to identify how weaker sections of community could be reached;

9. to provide more female community health volunteers to render full range of maternal and child health services and not merely birth attendance as given by trained dais; and

10. reorientation of medical education with focus on Prevention Concepts of Primary Health Care and managerial and leadership roles of physicians.

ANNEXURE I

COMPOSITION OF GROUP 1 TO PREPARE THE DRAFT OF THE INDIA'S PLAN TO ACHIEVE THE OBJECTIVE OF 'HEALTH FOR ALL BY 2000 A.D.'

Group subjects:

i. Meaning of Health for All in the background of India's Health Needs.

ii. Indices (health indicators) to be achieved by 2000 A.D.

iii. Plan-wise phasing of the indices.

iv. Strategies to be followed.

1.	Dr. V. Ramalingaswami Director-General Indian Council of Medical Research	Chairman
2.	Mrs. P. Trivedi, Adviser Planning Commission	Member
3.	Shri N.N. Vohra Joint Secretary Ministry of Health and Family Welfare	Member
4.	Dr. K.C. Seal Director Central Statistical Organisation	Member
5.	Dr. B.N. Tandon Professor of Gastroenterology All India Institute of Medical Sciences	Member
6.	Dr. G.S. Mutalik WHO/SEARO	Member
7.	Dr. V.K. Rambhadran Director (E&I) Department of Family Welfare	Member
8.	Professor K. Ramachandran Head, Biostatistics Unit All India Institute of Medical Sciences	Member
9.	Dr. Mahendra Dutta Director, CBHI Directorate General of Health Services	Convenor and Member-Secretary

Special Invitees

10. Shri A.P. Atri
    WHO Programme Manager
    NMEP (P. Falciparum Containment Programme)

11. Dr. M.D. Saigal
    Deputy Director General of Health Services

12. Dr. N.P. Gupta
    Deputy Director General
    Indian Council of Medical Research

13. Dr. P.C. Sen
    Adviser (Nutrition)
    Directorate General of Health Services

14. Dr. N.K. Sinha
    Deputy Adviser (Health)
    Planning Commission

15. Dr. N.D. Datta Banik
    Assistant Director General
    Indian Council of Medical Research

16. Dr. J.P. Greaves
    Senior Programme Officer
    UNICEF Regional Office

RECOMMENDED LIST OF HEALTH INDICATORS FOR FORMULATION OF STRATEGIES OF HEALTH FOR ALL BY THE YEAR 2000 A.D.

Minimal List	Additional to be developed
I. Health Impact Indices:	
(A) Negative Indicators	- Neonatal mortality rate
(a) Mortality	- Perinatal mortality rate
- Crude death rate	- Cause specific death rate
- Infant mortality rate	(of diseases of health importance)
- Pre-school child death rate	
- Maternal mortality rate	
- Morbidity	- Incidence/prevalence rates
	(of diseases of health importance and case fatality rates)
(B) Positive Indicators	
- Life Expectations (at birth)	- Average birth weight or percentage births with birth weight 2500 g.
	- Average height and weight of children 0-4 years
II. Health Services Indices:	
(a) Health activities indices	
- Percentage completed immunization (TT, DT, DPT, BCG, Polio, anti-typhoid)	- Percentage of infectious TB cases effectively covered under treatment
	- Percentage of infectious Leprosy cases effectively under treatment
- Percentage covered by iron-folic acid supplement	

i. expectant mothers
ii. children
- per cent reduction of cataract blindness

- Percentage covered by Vit. 'A' prophylaxis
- percentage of endemic population effectively covered by supply of iodised salt

(b) Family Planning Services:

- Crude birth rate

- Number of acceptors per 1000 eligible couples (separately for each method)

- Percentage of eligible couples effectively protected

- Average birth interval

- Average parity

- Mean age at first marriage (female)

- Average family size

- Gross reproduction rate

- Natural growth rate

- Net reproduction rate

(c) Availability of Health Services Indices:

- Doctor: population ratio
- Census of health professionals

- Dentist: population ratio

- Nurses: population ratio
- Percentage of villages covered under HV scheme

- Auxiliary nurse midwife: Population ratio

- Bed: population ratio (rural and urban)
- Percentage of rural

- Primary health centre: population ratio

- Suc-centre: population ratio

- Percentage of PHC's upgraded (to rural hospitals)

- Population covered under CHV scheme

III. Physical Quality of Life Indices:

- Percentage of population covered by protected water supply (rural and urban)

- Percentage of population covered with safe excreta disposal (rural and urban)

- Per capita calorie and protein intake

- Per capita consumption of different foods

- Percentage of population (by age groups) showing signs of nutrition deficiency (by class)

ANNEXURE III

STATEMENT SHOWING TARGETS OF 'HEALTH FOR ALL BY 2000 A.D. AND THEIR PLAN-WISE PHASING

Index	National averages				
	Present	1985	1990	1995	2000 AD
Crude death rate	14.1	11.0	10.4	--	9.0
Infant mortality rate	129	--	80.90	--	Below 60
Perinatal mortality rate	60-109	--	--	--	30-35
Pre-school (0-5 years) death rate	35-40	--	20-25	--	10
Maternal mortality rate (MMR)	5-8	--	-	--	Below 2
Life Expectancy at birth	52.6 M 51.6 F	--	58.0 M 57.7 F	--	64 yrs.
Birth weight below 2500 g.	30%	--	--	--	10%
Crude birth rate (per 1000)	33.2 (1978)	29.5 (1983)	27.0 (1988)	--	21.0
Percentage effective couples protection	22.0	35	44	--	60.0
Mean age at first marriage (female)	17.2 (1971)	20	--	--	--
Net reproduction rate	1.67	--	--	--	1.0
Natural growth rate	1.9 (1978)	1.79 (1983)	1.66 (1988)	--	1.26
Family size	4.3 (1979)	--	--	--	2.3
Percentage pregnant mothers receiving ante-natal care — Rural	56.3 (estimate)	--	--	--	0
Percentage pregnant mothers receiving ante-natal care — Urban	46.3 (estimate)	--	--	--	0

Percentage of deliveries by trained birth attendants		10-15% (estimate)	--	--	--	100
Percentage population with protected water supply	Rural	10	--	100-	--	100
	Urban	80	--	100	--	100
Percentage population with sound excreta disposal	Rural	--	--	25	--	50
	Urban	34	--	80	--	100
Immunization status (percentage coverage of pregnant mother and infants						
a. TT		21	60	87	--	100
b. DPT		51	70	83	--	100
c. Polio		18	43	80	--	100
d. BCG		65	70	83	--	100
Percentage coverage Primary Health Centres for 50,000 population		--	30.8% (1983)	50% (1988)	80% (1983)	100%
Percentage coverage of Sub-centres one for 5,000 population		--	71% (1983)	100% (1988)	--	--
Percentage coverage Nutritional supplement (iron and folic acid)		--	--	100% (1983)	--	--
a. Expectant mother		--	60 million (1983)	100% (1988)	Main-tenance	--
b. Children		--	60 million (1983)	100% (1988)	--	--
Percentage covered by Vit. 'A' prophylaxis		--	--	--	--	--

REPORT

OF THE

SUB-GROUP ON INTER-SECTORAL COORDINATION

TO ACHIEVE

HEALTH FOR ALL BY 2000 A.D.

Five Working Groups on five different subjects were set up to prepare reports on the various components of the National Plan to achieve the objectives of Health for All by 2000 A.D. One of these Working Groups was on Inter-Sectoral Coordination, with the following composition:

1. Smt. P.P. Trivedi Adviser (Health) Planning Commission	Chairman
2. Smt. Nirmala Buch Joint Secretary Ministry of Social Welfare	Member
3. Shri A. Bordia Joint Secretary Ministry of Education & Culture	Member
4. Shri M.M. Rajendran Joint Secretary Dept. of Social Welfare	Member
5. Shri B.K. Sharma Joint Secretary Ministry of Rural Reconstruction	Member
6. Shri P.K. Chatterji Adviser (PHE) Ministry of Works & Housing	Member
7. Shri Ahmed Masood Dy. Development Commissioner Ministry of Petroleum & Chemicals	Member
8. Shri N.N. Vohra Joint Secretary Ministry of Health & Family Welfare	Convenor and Member-Secretary

2. The Working Group held two meetings (on the 5th and 25th March, 1980) and had discussions on the various aspects of inter-sectoral coordination for achieving the objective of Health for All by 2000 A.D. The guiding objective of the deliberations of this Working Group was the opening paragraph of the Declaration of Alma Ata which reads as follows:

> "and that the attainment of the highest possible levels (of health) is a most important worldwide social goal whose realisation requires the action of many other social and economic sectors in addition to health sector."

3. The other parts of the Declaration and of the recommendations of the International Conference on Primary Health Care also emphasize the need for formulation of national policies, strategies and plans of action to launch Primary Health Care Programmes as part of the national health system in co-ordination with other sectors. To achieve this objective, the mobilisation of national resources in all sectors is most essential. The resources of the developing countries are limited and the needs are far too many. Efforts at achievements of the desired goals in any field of activity without a co-ordinated plan of action are bound to be wasteful in time and resources, if pursued in a fragmented and isolated manner. Attainment of nationwide goals, specially social objectives, is possible only through sustained national will and co-ordinated efforts by all related sectors. This is specially true of the health sector. Health Development is both a cause as well as a result of social and economic development. Any ideal health policy should, therefore, be an integral part of overall development policies, reflecting the social and economic goals of the government and the people. In such an integrated approach the health and social and economic sectors will be mutually supportive and contribute towards the achievement of the ultimate goals of the society. In the aforestated context the Group very clearly realised that health of a nation cannot be achieved through the efforts of only the health sector. It has to be an integral part of the national strategies in all sectors of social and economic development.

4. The Group undertook a broad appraisal of the plans and strategies of the various Ministries/Departments engaged in the implementation of social programmes. It was realised that almost all the sectoral plans have been largely conceived on the basis of isolated approaches. Some of the programmes on the social development front appear to be quite independent of each other and in some cases parallel efforts are being made, with obvious overlaps.

5. In the field of health, the Centre and the States have achieved some mentionable gains, in the three decades and more since independence. A network of Dispensaries, Sub-Centres, Primary Health Centres and Hospitals has been established. Large manpower has been trained and placed in the field. Mentionable advances have been made in the related fields of nutrition, maternal and child health care and family welfare. Efforts have also been launched in integrating health and family welfare aspects at the various levels of the health delivery organisational structure. In view of the very large population base, very high rates of growth and lack of satisfactory management have, together, stood in the way of our efforts, so far, making a positive dent on the health scene.

6. It is imperative that if we are to seriously contend to achieve meaningful results within the next about two decades, within the constraint of financial resources which, in relative terms, are bound to continue to exist, then there is no alternative to the exploitation of available manpower and financial resources, available with the various agencies concerned with health, in the most well-planned and coordinated manner.

7. The Group agreed that, in the first phase, efforts at achieving coordination may cover adult education, social welfare, efforts aimed at improving the

lot of women and children, water supply and sanitation, manufacture and supply, at reasonable cost of essential, life-saving drugs, efforts at eliminating social evils of alcoholism, drug addiction etc.

8. Towards the objective stated in the fore-going para extensive discussions were held by the Group, with members representing the various concerned Departments/Ministries. The broad emerging picture has been brought out briefly, in the following para.

9. *Water Supply and Sanitation*

9.1 The Ministry of Works and Housing have drawn up a Water Supply and Sanitation Plan for 1980-90. This Plan is in line with the objectives which were unanimously adopted at the United Nations Water Conference at Mar del Plata, Argentine, in March 1977, *viz.* that the orderly administration of water resources is a key factor to improve the economic and social conditions of mankind, especially in the developing countries. According to the World Health Organisation, 80 per cent of all sickness and diseases in the world is attributable to contaminated water. The contributions that safe water supply, sanitary disposal of excreta and other wastes, food, sanitation and personal hygiene can make to Primary Health Care are undeniable.

9.1.2 The Minitry of Works and Housing organised a Workshop on International Drinking Water Supply and Sanitation Decade in November 1978, attended by the Chief Engineers from the States to discuss the accelerated Sector Development and constraints likely to hamper such development. A rough assessment of the projected requirement of funds for the Decade indicates that over Rs.15,000 crores would be needed to provide the basic minimum services to all the people in the country. A letter has been written by the Ministry to all the Chief Secretaries in the States, in February 1980, highlighting the importance of adequate preparations for launching the International Drinking Water Supply and Sanitation Decade and requesting them to organise necessary spade work, in this connection, at the State level. Action to prepare the Natonal Plan in connection with the International Decade has also been initiated. The States have been requested to intimate data on the projects and their cost which will be used for formulating requirements of foreign assistance. The World Health Organisation have been requested to obtain the services of suitable Consultants to prepare specific guidelines for feasibility reports in respect of the major projects which are to be posed for assistance from the World Bank and other international agencies.

9.1.3 The projected requirement of funds for fulfilling the targets set for the Decade, namely, provision of water supply and sanitation facilities to all the people in the country (both urban and rural) will be as follows:

i. Urban water supply	Rs.3,044 crores
ii. Urban sewerage	Rs.2,432 crores
iii. Rural water supply	Rs.7,057 crores
iv. Rural sanitation	Rs.3,301 crores

The above requirements indicate the staggering size of the problem. The

related targets for coverage by 1990, as recommended by the Conference of Chief Engineers, is as under:

i. Urban water supply	100 per cent	
ii. Rural water supply	100 per cent	
iii. Urban sewerage and sanitation	100 per cent	In respect of Class I cities and 50 per cent in respect of Class II and other cities. Overall coverage in the States should be 80 per cent by means of sewerage or other simple methods of disposal.
iv. Rural sanitation	25 per cent or more to be covered with	sanitary toilets.

It has been realised that if the levels of services and methods of implementation remain the same as in the past, it would be difficult to achieve the targets of the Decade. There is a need to ensure low unit cost and standards of services as well as much expanded mobilisation of local community and external resources. Keeping this in view an exercise has been carried out in the Central Public Health and Environmental Engineering Organisation (CPHEEO) to work out the projected requirement of funds for water supply and sanitation programme for the Decade for urban and rural areas, which is summarised as under:

Items	Rupees in crores
1. Urban water supply	2,475
2. Urban sewerage and sanitation	2,590
3. Rural water supply	4,288
4. Rural sanitation	1,584
Total	10,877

9.1.4 The Draft Sixth Plan (1978-83) provides for about Rs.2,700 crores for the water supply and sanitation sector. The present annual level of investment is, on an average, about Rs.540 crores. It would need to be increased to a level of about Rs.1,083 crores per annum during the Decade if the said targets are to be achieved. This Group would, therefore, suggest an increase in the level of annual investment in water supply and sanitation programmes to the level of Rs.1,088 crores. It further suggests that the outlay for these programmes for the period 1978-83, 1980-85 and 1985-90 should be as follows:

1978-83	Rs.2,700 crores
1980-85	Rs.4,000 crores
1985-90	Rs.6,000/Rs.8,000 crores

The Group noted that this realisation would have to be kept in view while preparing the Annual Plans so that adequate funds are generated from all sources, including the recoveries from the beneficiaries, contributions by the State and Central Governments as well as assistance procured from external sources.

9.1.5 Other steps, besides raising of financial resources, would also have to be taken. These would include stepping up the production of different materials required for the projects under the Decade Programme. The cost of pipes and other essential materials form major portion of water supply estimates, say, as much as 50-60 per cent. Advance action will have to be initiated, involving the Ministry of Industry as well as private industries, to step up the production of these materials. Training facilities available in the existing institutions and involving of additional institutions to take up the training of technical personnel, so that sufficient number of trained personnel to plan, design, execute and maintain the systems to be extended during the Decade will have to be planned and augmented.

9.2 *Education*

9.2.1 The role of the Ministry of Education and Culture is crucial to the achievement of Health for All. Education has a direct bearing on all efforts to promote health. Excluding the age group 0-4 India has 307 million illiterates (1971 census). With such a large illiteracy base efforts at health education become difficult and, therefore, all the more important. Then there is the challenging task of inculcating the principles and practices of good health among school goers, at all levels. Taking an overall view of the role of health education in appreciably reducing the problems of ill-health, the Group felt that the most urgent and well-planned steps are required to be taken to introduce health and population education at all levels of the school and university education.

9.2.2 The National Adult Education Programme launched by the Government of India in 1979 aims at the extension of education and educational facilities to the entire population of illiterates mainly in the 15-35 age group, numbering about 100 million, within about five years. The NAEP incorporates the essential features of non-formal education. It aims at literacy and numeracy of a sufficient level to enable the learners to continue self-reliant learning, functional development of an individual as a producer and a worker as a member of the family and as a citizen in a civic and political system, and social awareness including awareness about the impediments to development. The instructor under this programme is assisted in his work by field level Government functionaries of the various Development Departments. When the subjects of Health and Family Planning are under discussions the Auxiliary Nurse Midwives (ANMs) and other staff of the Primary Health Centres are expected to participate.

9.2.3 The target fixed for the period 1978-83 is 65 million and the corresponding requirement of funds has been worked out at Rs.686 crores. The requirement of funds for covering a population of 100 million comes to Rs.1,056 crores. Obviously, the requirement of funds for covering a population of 307 million of illiterates will, on a rough basis, be three times more say approximately Rs.3,250 crores. This requirement, keeping in view the fundamental importance of the programme, is not beyond mobilisation. As ill-health disease and fatality is the highest amongst this segment of population, the Group felt that any delution of the NAEP targets would, even in the short run, prove to be an extremely expensive venture and result in retarding social

awareness and human development which, in turn, would have an adverse effect on economic development.

9.2.4 The Group observed that, as yet, adequate plans for the training of trainers have not been envisaged under the NAEP. While there is no doubt that the field functionaries of the various developmental organisations of the Government are in a position to impart necessary awareness to the illiterates, they are not adequately and appropriately oriented or trained for carrying out such tasks. The Group acoordingly recommended that suitably conceived orientation and training programmes for the trainers should be launched on a time bound basis. The lesson plans on various subjects, including health, hygiene and sanitation should be clearly identified and formulated in the easiest and most comprehensible terms, preferably through simple audio-visual aids.

9.2.5 The Ministry of Education and Culture have not as yet worked out targets and corresponding targets for the 2000 A.D. perspective. The Group could also not inform itself adequately as regards the mechanics envisaged in securing the crucial coordination among the efforts being launched by the large number of developmental organisations operating in the field; how and to what extent the field functionaries of the various other organisations can be utilised for achieving the objectives of NAEP; the method, time and costs involved in rearing the requisite number of trained trainers to achieve the NAEP targets, and, whether the additions to the population of illiterates during the coming years, on account of the growth of population, has been taken into account for future planning.

9.2.6 The Group was of the considered view that a well conceived School Health Programme requires to be drawn up and implemented on a time bound basis. The efficient and effective enforcement of such a programme would, besides extending the concepts of health consciousness and prevention of disease amongst the school goers also has the tremendous advantage of upgrading the levels of awareness of their families as well as of the social groups in which they live.

The Ministry of Education and Culture, through the National Council of Educational Research and Training (NCERT), is attempting to improve the formal and non-formal education in the country. In these efforts, education has been envisaged as a tool to bring certain behavioural changes in the future citizens of the country. Behavioural change is considered more important than the development of functional awareness about health. For this reason the NCERT have taken up programmes for the effective teaching of concepts pertaining to health. These activities are in the form of instructional materials like syllabus, textbooks, teachers' guides, laboratory manuals etc. A number of these programmes, like Nutrition Education Project, Primary Curriculum Development, etc. are directed towards the strengthening of the teaching of all the concepts of health education. In order to develop environment based or community linked education very close cooperation is required between NCERT and all the agencies which are concerned with the implementation of health education. The Group noted with satisfaction that NCERT have formed a Working Group in the Council to strengthen health education. Special attention

is being given to the elementary level (upto age group 14+). The concepts of health education have been inducted in different disciplines and presented through reading materials of formal and non-formal education. Besides text-books, a number of supplementary reading materials on health education have been put by the NCERT. They have also developed toys to explain these concepts and tried out in the school education programmes. At the secondary and higher secondary level, health education is included in the instructional materials. The NCERT has collected valuable information about the present status of medical check-up and vaccination in the schools of the country. The health education textbooks have been developed jointly with the Central Health Education Bureau for classes IX and X as a part of NCERT's efforts to strengthening health education. It also forms a significant part in the syllabus of physical education. As the majority of the students give up formal education after the middle stage, health has been given top most priority in the subject matters of this level. Special experimental programmes include arrangements for constant monitoring so that improvements are made at each stage of implementation.

The relevant recommendations of the Alma Ata Conference being in conformity with the Belgrade Charter on Environmental Education, which have been accepted by the Government, the Group is of the considered view that there is need to formulate an exhaustive approach paper on health education, specifying clearly the rationale, strategies, expected outcomes and evolving of action programmes on the basis of National Education Policy and the National Health Policy, also keeping in view the recommendations made in the above Conferences. There is also urgent need to undertake experimental projects, in selected areas, to establish viable models for generating appropriate mechanisms of involving all related agencies in the field of health education. Health is the most important component of the environment and is constantly interacting with other components of the environment, thus resulting into a "system" which is not uniform all over the country. There is, therefore, an urgent need to identify this 'system', especially in the socially deprived areas. The NCERT who are doing good work in the field of health education need to utilise the services of all their Departments, numbering about 30, for taking up appropriate programmes to strengthen health education. Training programmes also need orientation wherein health should be stressed not as a discipline but as part of one's life and teachers must be equipped to offer proper counselling and guidance to the child in solving their day-to-day problems. The Group feels that health education should not remain only within the confines of school education but should also be included actively in the education programme of the colleges and universities. Further, concrete programmes in this direction require to be built up by the Ministry of Education in coordination with the Ministry of Health and Family Welfare and the initiatives already launched in the field of health education at the university level finalised and implemented on a time bound basis.

9.3 *Drugs*

9.3.1. One of the recommendations of the Alma Ata Conference is that the Governments should formulate national policies and regulations with respect to the import, local production, sale and distribution of drugs and biologicals

so as to ensure that essential drugs are available at the various levels of primary health care at the lowest feasible cost; that specific measures be taken to prevent the over-utilisation of medicines; that proven traditional remedies be incorporated; and that effective administrative and supply systems be established. Within this framework the question of our existing capacities in the selection, supply and proper use of essential drugs was looked into by the Group. This Group had before it the findings of the Working Group set up on this subject by the Planning Commission, in April 1978, to formulate targets and programmes for the Drugs and Pharmaceuticals Industry for the period 1978-83.

9.3.2 The current production covers a wide range of bulk drugs and a host of other synthetics, besides practically the entire range of formulations demanded by the medical profession. The technology adopted for the production covers intricate and sophisticated ones in the field of fermentation, synthetic operations and extraction and purification of the active principles contained in the plant and the animal kingdoms. As regards the financial requirements for the manufacture of bulk drugs it has been estimated that Rs.720 crores will be required for the period 1983-84. The projected quantum of bulk drugs would result in the production of formulations of the value of Rs.2,160 crores during 1983-84. On an overall basis, investment in the public and private sectors is expected to be of the order of Rs.150 crores and Rs.400 crores respectively. These figures indicate the gap in the resources required as per envisaged demands.

9.3.3 The Group examined issues relating to the pricing of bulk drugs, price control etc. and noted that custom duties on the import of some 22 bulk drugs required for the production of essential life saving formulations, have been withdrawn. The benefit of withdrawal of the custom duties on the bulk drugs has been passed on, wherever possible, to the consumers by reducing the prices of formulation based on such drugs. The wholesale price index for drugs and medicines for the period April to October 1979 registered a marginal decline as compared to wholesale price increase for drugs and medicines during the year 1978-79. The Group felt that there is a need to take further measures to reduce prices, specially those of essential and life saving drugs.

9.3.4 For meeting the drug requirements of the governmental sector, it was suggested that further reduction in the costs could be achieved by working out, in advance, the quantities of the specific medicines required for distribution through government run/controlled hospitals and dispensaries. Such advance assignments would enable the units in the Central public sector to secure significant economies of scale. The possibility of establishing a company, preferably in the public sector, which would organise all the purchases and even perhaps get formulations manufactured on jobbing basis could be examined. There are further possibilities of reducing the cost of production if only optimal quantities of excipients are used. This aspect could be gone into by the Drugs Controllers. Similarly, significant savings could be secured by standardising packaging. Only those packing materials may be allowed to be used which could bring down the cost without impairing the quality of the drugs, saving high expenditures on publicity and sales promotion packings.

9.3.5 Perhaps the most significant reduction in costs could be achieved by ensuring that all institutional purchases are made of generically branded drugs and formulations. No excise duty is leviable on drugs sold under their generic names. The Group noted that adequate action on these lines has still to be initiated by the Health Ministry and, accordingly, urged urgent moves in this direction. As regards the requirements of vaccine and sera, the facilities already available with the Ministry of Health and Family Welfare could be further augmented and measures taken to achieve self-sufficiency by the year 2000. The Group recommended that while projecting the requirements of medicines/vaccines, the requirements of family planning devices should also be similarly worked out. The need to enforce prevention of adulteration laws more effectively was also emphasised by the Group.

9.4 *Community Involvement*

9.4.1 The Ministry of Rural Reconstruction is primarily responsible for community institutions and implementation of certain basic rural reconstruction programmes. The Group felt that this Ministry may make all out time bound efforts to mobilise community participation in the implementation and management of all developmental programmes. It was noted that some of the past failures and poor development have been due to the fact that the community is either not involved at all or very poorly involved in the initial planning of schemes and programmes. It is for this reason that implementation and subsequent management are looked upon by the community as the sole responsibilities of the government. It was noted that effective community participation would not only contribute to a significant reduction in the costs of projects but also ensure their proper management. The Group felt that community participation in the construction of Sub-Centres, Primary Health Centres, implementation and maintenance of water supply works and sanitation programmes were concrete areas in which mobilisation efforts could be launched. It was noted that contributions in the form of labour can be secured very easily. The Group felt that, for the beneficiaries to value the facilities created for their welfare, it may be worthwhile for a token charge being imposed, perhaps per every rural household, for the services received. It was also agreed that there has been very meaningful and effective coordination between the Government, at the various levels, and the voluntary organisations active in the field. The Group noted that in a large number of villages the panchayat is non-functioning. It was felt that in such areas alternative bodies may be selected for mobilising community participation. It was appreciated that while duplication of efforts (manifested by the multiplicity of field functionaries) cannot be avoided in so far as the transfer of skills in the rural areas is concerned, there is scope for ensuring against too many uni-purpose workers in the social services sector. This would not only result in economies but perhaps also lead to better results.

9.5 *Developmental Programmes for Vulnerable Population Groups*

9.5.1 The Department of Social Welfare of the Ministry of Education and Culture looks after the planning and implementation of programmes for the

welfare and development of women, children and handicapped persons. The Group noted that any strategy of Health for All by 2000 A.D. will have to ensure very good implementation of the specific measures and methodologies for the delivery of health services, including preventive measures, to ensure health and welfare of these sections of society. This is extremely essential as the access of these crucial sections of the society to the health services, wherever available, is much less than of the higher socio-economic groups which are better placed to make use of the services. Moreover, certain preventive measures and interventions to provide nutrition, sanitation, health education etc. to these groups would be very directly conducive to the achievement of the goal of Health for All.

9.5.2 The Group is of the opinion that "women's groups" and their activities can be a very useful delivery point for rendering services to women, including health services. Such groups can be very useful points for health education as well as education for family welfare. Such groups, to be effective and viable, would require budgetary and other supports for being enabled to take up effective activities also keeping in view/the increase in population, in the future. The Group noted with satisfaction that the Social Welfare Ministry have made a provision for assisting Mahila Mandals for taking up such activities, by giving them a small revolving fund and for taking up the training of Mahila Mandal members. For any appreciable impact and use of women's groups to ensure delivery of health services through them, at least villages with a population of 1000 should have a womens' group which should be assisted to be an active and viable delivery point in the village, for rendering services to village womenfolk. On this basis the number of women's groups needed to be promoted by 2000 A.D. has been assessed by the said Ministry to be 1,24,313 requiring financial support of Rs.130 crores. The Group is of the view that the above target should be increased and that we could have at least 2,50,000 women's groups for the same number of villages in the country by the year 2000 A.D. Naturally, such enhancement of targets would involve almost doubling the financial support. The Group was of the considered view that this activity is required to be undertaken in very effective coordination with other developmental activities including health, adult education etc. The other important programme being taken up by the Social Welfare Ministry is the network of child care centres, supporting women employment as well as rendering services to children. The Social Welfare Ministry, through the Central Social Welfare Board also takes up a number of programmes which provide very useful entry points for delivering much needed health and other services to the vulnerable sections of society. These activities are also taken up through the voluntary organisations and include grants to hospitals, medical camps, camps for health check up, organisations providing maternity services, orphanages, homes for the infirm and the aged. It has been estimated by the Social Welfare Ministry that the number of beneficiaries under the various schemes, namely, Orphanages and Foundling Homes, Pre-primary School/Balwadis, Cultural/Recreational Centres and Libraries for Children, Creches, Maternity Centres, Welfare of Handicapped, Homes for Aged and Infirm, Infant Health Centres and General Medical Aid, Nutrition, and Camps for training of rural women in leadership and public co-operation will be about 45 lakhs by the year 2000. This is far too insignificant a figure. The Group is of the view that the coverage

under these various programme requires to be raised at least ten-fold to have a meaningful impact.

9.5.3 The Nutritional Intervention Programmes and the Integrated Child Development Services Programme of the Social Welfare Ministry need to be rapidly expanded so that we could achieve better health of at least the vulnerable and disadvantaged groups of the society, particularly the children and women. A package of integrated services could be delivered in the further and future expansion of these programmes. The ICDS Programme which particularly aims at the development of the children could expand to provide, in a package form, primary health care to children and nursing expectant mothers. Presently the programme touches only the fringe of the problem considering that only 200 ICDS projects stand sanctioned, whereas we have about 5,500 Blocks in the country and 115 million children below six years of age as per the 1971 census. The Group is of the view that while it is difficult to foresee the availability of the requisite resources, it would be necessary as assessed by the Social Welfare Ministry, to have at least 4,525 ICDS projects in the country by the year 2000 A.D. The gap, which is quite small, may be filled up by the State Sector ICDS projects. The estimated expenditure by the year 2000 will be Rs.2,419.20 crores. Though this appears too large a requirement the Group felt that it should be our objective to work towards providing these resources, in a phased programme, to achieve a mentionable dent, in our overall approach to secure health for all by 2000 A.D.

10. The Group was of the considered view that the satisfactory achievement of an objective of the nature of Health for All by 2000 A.D. could be secured only through integrated socio-economic development, planning and implementation. It was noted that currently there is no integration of social welfare objectives in plans of economic development except in a very broad sense. The Group felt that positive moves in this direction require to be launched, to ensure that every economic development project ensures against environmental pollution and positively provides for housing, health, adult education and other related aspects which are currently getting altogether neglected or receiving very piece-meal attention.

10.1 The Group appreciated that even if meaningful and urgent moves were made to ensure fully integrated socio-economic development the desired gains in the social welfare sector may not become available for quite some time. It was also noted that it may not be an altogether easy task to bring about in the immediate future, the requisite corrective changes in the currently accepted planning models. Thus, taking overall practical view of the prevailing status of social and human development and being cognisant of the urgent importance and enormity of the challenges before the country and the need for integrated programmes and coordination in implementation, the Group made the following recommendations:

i. The Working Group on Population Policy has recommended that population policy structure should be headed at the highest level by the Prime Minister. No population policy programme which mainly would include family planning can succeed without a full package of health services. Therefore, the Group/Committee constituted for the population policy programmes may also be entrusted with the task of coordination of

'Health for All'. At present there is a Cabinet Committee on Population Policy headed by the Prime Minister. This Committee is at present not functioning. It could be reactivated and could become the apex body at the national level.

ii. The Planning Commission may coordinate the social development programmes to include health, nutrition, water supply, sanitation, education, social welfare, population policy etc. through a member placed incharge of the whole sector. This may be formalised by setting up a Committee headed by the Member with Secretaries of the Ministries concerned as members. It may also coordinate Minimum Needs Programme. If this committee is constituted, the Committee of Secretaries with Cabinet Secretary as Chairman to coordinate Minimum Needs Programme may not be necessary.

iii. In the States also, the State Governments should constitute the Coordination Committees under the Chief Minister and an Executive Committee with Chief Secretary as Chairman. The programmes may be coordinated by suitable existing or if necessary new coordination committees at divisional, district and block levels through Divisional Commissioners, Deputy Commissioners/Collectors and Block Development Officers.

iv. The Coordination to be effective should be started from the base implementing level, namely, the village. The Gaon Panchayats which could have undertaken this work are riddled with factions, politics and corruption and dominated by higher castes and class are indifferent, if not exploitive of, the difficulties of the weakest and have also become defunct. An organisation at the village level must be immune from these drawbacks. It is, therefore, suggested that a village or group of 50 households in a village may form a village or sub-village council with one representative from each household. The representative may be in the age-group 30-60 residing in the village. A member of the household not regularly residing in the village should be ineligible. The age-group 30-60 has been suggested to enable the member to have a say and stake in the decision-making. The Council should meet once a month on a fixed day and time.

v. Such a programme has been started in Nagaland and is making good progress. If any State experiences any difficulty in organising the village councils in view of the strong lobby of gaon panchayats, a village council of the harijans and landless may be made which may be the only village body for their programmes. It will have an integrated look at village development including health.

10.2 It was the unanimous concensus of the Group that the objectives of Health for All by 2000 A.D. are not beyond reach but not much success is likely to be achieved without sustained political will and support both at the Centre and in the States.

REPORT

OF THE

SUB-GROUP ON COMMUNITY INVOLVEMENT

TO ACHIEVE

HEALTH FOR ALL BY 2000 A.D.

The Group on Community Involvement met in New Delhi on March 18. The following were present:

1. Dr. K.S. Sanjivi 11, Link Street Q.I.T. Colony Madras-600 004	Chairman
2. Dr.(Mrs.) B.J. Coyaji C.M.O. King Edward Memorial Hospital Sardar Mudliar Road Rasta Peth Pune-400 011	Member
3. Shri R.R. Gupta Joint Secretary Ministry of Health & Family Welfare	Member
4. Dr. Vijay Kumar Health Community Medicine Post-Graduate Institute of Medical Education and Research Chandigarh	Member
5. Dr. L. Ramachandran Director Gandhigram Institute of Rural Health Gandhigram (Dist. Madurai)	Member
6. Shri V.N. Kakar Chief(Media) Department of Family Welfare	Convenor & Member-Secretary

Dr. R.S. Arole, Director, Comprehensive Rural Health Project, Zamkhed-413 201 (Dist. Ahmednagar) could not come.

2. The Group recommends that the concept that health is not only a basic right of man but also one of his essential responsibilities must be promoted vigorously in order to bring about greater community involvement in health care programmes. The community at present looks at health as the sole responsibility of the State as something to be administered by the Government to the people. This tendency needs to be changed. The community should be given the feeling that promotion of health is a joint responsibility to be shared by the Government and the people.

3. There cannot be any uniform pattern for the involvement of the community in health care programmes for the country as a whole or even for any single

region. Depending upon the needs of the situation and availability of infrastructure and other resources, the pattern of community involvement will inevitably differ from place to place. The important thing is that all sectors of the community should be associated with health care programmes at all stages - from planning to actual utilisation of resources. The community should be encouraged to make monetary contributions to these programmes.

4. The Group feels that to bring about greater involvement of the community in health care programmes, it is important that entry points, in tune with local felt needs, should be identified. Once the community gets the confidence that health programmes will help it in meeting its own needs, the participation of the community in these programmes can be achieved with less difficulty.

5. The Group recommends that in relation to community involvement, health care should embrace all aspects of health and family welfare, including maternal and child health programmes, nutrition programmes and family welfare services.

6. The Group feels that the community health volunteers inducted in the rural scene in the recent past can play an extremely useful role in bringing about community participation in health programmes in villages. The weaknesses in the scheme as have come to light must be removed quickly. The Group is of the strong view that there should be no compromise with the essential principles of the scheme - *viz.* volunteers should not be Government functionaries, they should command respect amongst the people they seek to serve, they should live in the villages where they work and they should be available to the community in all times of need. The Group recommends that the scheme of community health volunteers should be strengthened and enlarged with modifications wherever considered necessary.

7. The Group feels that in every village there should be two community health volunteers and at least one of them must be a woman. This is particularly essential from the point of view of involving women in maternal and child care as well as family planning programmes.

8. The Group feels that the importance of the mother for promotion of health within the family and, through the family, in the community as a whole has not received due recognition from health planners. The mother has a vital stake in the health of her children and cleanliness of her home. The Group feels that special programmes should be designed to encourage mothers to emerge as leaders in community participation in health care.

9. Cleanliness of the body and the mind is an essential concept embedded in the Indian cultural ethos. The Group feels that health education programmes have failed to take advantage of this situation. Further, whatever be the other weaknesses of these programmes, these are far too inadequate and one does not find much evidence of their existence in the society. In the old days hygiene used to be one of the subjects taught in schools. At present in most of the States health education has not been included in the formal education system. The Group notes with regret that even though at numerous

conferences recommendations have been made that health education must become an integral part of the school system, these recommendations have not been implemented in most of the States. The Group feels strongly that if health is one of man's basic rights and responsibilities, health education must receive its due place in the formal education system.

10. The Group further recommends that health education should be inducted in all programmes of non-formal education for various sectors of the society - *viz.* agricultural extension workers, industrial workers, cooperative societies and organisations devoted to social welfare, particularly welfare of women and children. The Group also recommends that health education should be promoted systematically through the National Adult Education Programme launched by the Ministry of Education.

11. The Group took cognizance of the media explosion which the country has been witnessing for several years. It notes with regret that even though mass media provide immense scope for the promotion of health care programmes and for the participation of the community in such programmes, these have been utilised only marginally and not in a systematic manner. The Group feels that the Government, both at the Centre and in the States, should take the lead in remoulding this situation. There is dearth of films and other audio-visual media material on health education. There is not much evidence of large-scale and systematic utilisation of print media. Drugs and cosmetics are advertised on a massive scale through all media. Their mounting sales reflect the potential of these media. This potential should be used in a planned and systematic manner by the Government in promoting the positive aspects of health and in achieving greater participation of the people in them.

12. The Group feels that at the grassroots greater use of inter-personal communication should be made to promote people's involvement in health care programmes. The Group notes that the Ministry of Health and Family Welfare has launched a large-scale programme of organising orientation camps of opinion leaders in villages in order to promote family welfare. The Group recommends that general principles of health care should always find reflection in family welfare and the forum of orientation camps should be utilised fully to increase the community's involvement in all health care programmes. The Group further recommends that women should be encouraged in particular to take part in the orientation training camps.

13. The Group feels that Government-sponsored programmes for the involvement of the community in health care should have an in-built mechanism of evaluation. The Group further suggests that those responsible for conducting these programmes should be given refresher courses from time to time.

(Note: The Group did not consider specifically the role of voluntary organisations in community participation programmes because this matter is being taken up in greater depth by another group).

SUB-GROUP 3: ADDITIONAL NOTE FROM THE CHAIRMAN OF THE GROUP

The recommendations of the Group prepared by the convenor and approved by me contain all the points on which there was unanimity during the discussions. I had circulated to the Group a note on the subject containing my views. The following two points contained in my note are considered so important that I am sending these additional recommendations for the consideration of the entire National Committee on Health for All by 2000 A.D.

1. In continuation of para 3 of the Group's recommendations please add "community consists of all the families living in an area without any reference to their occupation or economic status. In our scheme for COHEDECs and Mini Health Centres it has been provided that each family should contribute, on behalf of all its members, 0.5 per cent of its annual income subject to a minimum of Rs.6 per annum and a maximum of Rs.180 per annum. Here let me quote Dr. Mahler, Director General of WHO, "Are the costs exhorbitant? Recent small-scale studies have shown that considerable improvements in people's health can take place for as little as 0.5 to 2 per cent of the yearly gross national product per person or what amounts to a few dollars a year. This is by any standard a reasonable cost, around a hundredth of what is spent on health by people in many rich countries. So cost factors should not hinder governments when they consider if, and to what extent, they should commit themselves to the target of Health for All by the year 2000 A.D.". (World Health, November, 1979).

2. The National Service Corps in the various colleges should be mobilised for non-formal and for health education in a big way. To my mind giving them such jobs as building roads is a rather futile exercise. It is understood that most Universities in India have taken a firm decision that community service should be compulsory for every student and that marks will actually be allotted for the same. More than the decision itself is the exact method of implementing the decision in such a way that the entire community gets maximum benefit, quite apart from the good it will do to the student's motivation.

REPORT

OF THE

SUB-GROUP ON THE ROLE OF THE

VOLUNTARY ORGANISATIONS

TO ACHIEVE

HEALTH FOR ALL BY 2000 A.D.

1. The Working Group constituted for making recommendations on the role of voluntary organisations in the context of the goal of Health for All by 2000 A.D. met at Nirman Bhavan, New Delhi, on 20th March, 1980 under the Chairmanship of Dr. K.N. Rao. The list of participants is given below:

1.	Dr. K.N. Rao	Health Association of India D-57, Naraina New Delhi
2.	Dr. M.G. Garg	General Secretary Indian Medical Association Indraprastha Estate New Delhi
3.	Mr. J.S. Bali	Consultant Voluntary Health Association of India C-66, Defence Colony New Delhi
4.	Dr. Daleep S. Mukarji	Programme Director RUHSA Melkavanur P.O. Via K.V. Kuppam Dist. North Arcot, Tamil Nadu
5.	Representative	Christian Medical Association of India Bangalore
6.	Representative	Ramakrishna Mission R.K. Ashram, Punchkuin Road New Delhi
7.	Shri R. Natarajan	Joint Secretary Ministry of Health and Family Welfare Nirman Bhavan New Delhi
8.	Shri R.R. Gupta	Joint Secretary (FA) Ministry of Health and Family Welfare Nirman Bhavan New Delhi
9.	Shri N.N. Vohra	Joint Secretary Ministry of Health and Family Welfare Nirman Bhavan New Delhi

10. Dr. M.D. Saigal

Deputy Director General (RHS)
Directorate General of Health Services
Nirman Bhavan
New Delhi

2. The meeting generally considered drawing attention to the following aspects of the matter *viz.*

i. the functions that could be assigned to the voluntary organisations in replacement/reinforcement of the work of State and Central Government systems at the field level; and

ii. the interaction and mutual relations between the Governmental system and the voluntary organisations.

3. After detailed deliberations, the following suggestions emerged:

(a) Voluntary organisations in this context could be defined as those organisations which are non-government non-profit making in character, and not fully funded whether directly or indirectly only by the Government. While private organisations also fall in the general category of non-governmental organisations, unless they fulfil the criterion of non-profit organisations, they could not be qualified for assistance from Government resources.

(b) There is a definite and important role for voluntary and recognised private organisations in delivering health care services as contemplated in the concept of Health for All by 2000 A.D. The work in this field cannot be carried out only by Government agencies; the work of all organisations in this field will require coordinated inter-meshing to make optimum use of all available resources - men, money and materials - to the nation.

(c) Promotion of community participation to the largest extent possible in order to generate demand for health services as well as utilisation of such services, should be a common goal of all organisations in this regard.

(d) Voluntary or recognised private organisations will have a role to play in all aspects of health services, such as service delivery at different levels from the periphery to the highest referral points - curative, preventive, promotive and rehabilitative, including prophylaxis coverage; education and motivation, including health education, training of para-medical or other workers, such as CHVs, Dais, etc., research into health care delivery system in all these aspects, including undertaking innovative approaches; field studies to test out assumptions in accordance with their capacity.

(e) In all the functions mentioned above, the goal of primary health care should be kept in the central focus. Voluntary organisations also should bear in mind cost effectiveness of their activities *vis-a-vis* governmental system.

(f) The need for coordination of activities of all voluntary organisations with those of the Government is of paramount importance. To achieve this and

also to maintain close and continuous dialogue between the Government and the voluntary organisations it would be necessary to set up Standing Committees at the Central, State and local levels. These Committees should look into all aspects of work as well as relationship between the Government and the voluntary organisations.

(g) Where voluntary organisations have taken root, duplication on similar services from the Government could be avoided, such as in the areas of mini-health centres of Tamil Nadu or similar programmes in other States.

(h) Recognition of voluntary organisations for their work as well as for the purpose of Governmental support to them would be a proper step. Procedures for this purpose may have to be worked out.

(i) The work of the voluntary organisations must have maximum flexibility suited to the capacity, manpower availability, areas of operation, financial strength, and the general objectives of each organisation. While, therefore, there should be no rigid pattern of assistance from the Government to such organisations, there would be need to make available some standard patterns around which changes can be made to suit each organisation.

(j) Voluntary organisation must be able to receive supplies from the Government for general programme purposes such as ANM Kits, vaccines for immunization, health education materials, WHO Handouts, etc. In addition, recognition by way of participation in policy making bodies would also give a boost to these organisations.

(k) Only those organisations which fulfil the criteria of voluntary organisations, as defined above, and which have a secular outlook and provide free accessibility to all sections of people, should be recognised and afforded assistance from the Government.

(l) In the field of providing financial assistance to voluntary organisations, establishment of an autonomous and financial body like the Agricultural Finance Corporation, etc. could even be considered. Such a body could receive a main corpus fund by way of support from the Government as also private grants, including grants from foreign donors. It could also be provided with annual subventions. Such a Corporation could make available funds in turn to voluntary organisations. For the purpose of raising funds, specially for health coverage, taxes, insurance, local cesses and people's contribution for services rendered according to financial status of the individual, could also be considered.

(m) The need for vertical as well as horizontal linkages of all voluntary organisations with the overall health infrastructure was repeatedly emphasized.

REPORT

OF THE

SUB-GROUP ON HEALTH SERVICES ORGANISATION

TO ACHIEVE

HEALTH FOR ALL BY 2000 A.D.

The composition of the Sub-Group on Health Services Organisation to achieve Health for All by 2000 A.D. is as follows:

1. Dr. N. Jungalwala Safdarjang Enclave New Delhi	Chairman
2. Mr. P. Murari Commissioner Health Government of Tamil Nadu Madras	Member
3. Dr. N.H. Antia The Foundation for Research in Community Health 84-A, R.G. Thadani Marg Sea Fall Corner, Worli Bombay	Member
4. Mr. Malcolm Adeseshia Member of Parliament New Delhi	Member
5. Dr. K.N. Udupa Director Institute of Medical Sciences Banaras Hindu University Varanasi	Member
6. Dr. L.P. Agarwal Director All India Institute of Medical Sciences Ansari Nagar New Delhi	Member
7. Mr. T.V. Antony Joint Secretary Ministry of Health & Family Welfare	Member
8. Dr. M.D. Saigal Dy. Director General (RH) Directorate General of Health Services	Convenor and Member-Secretary

Special Invitees

1. Mrs. Serla Grewal
   Additional Secretary
   Ministry of Health & Family Welfare
   New Delhi

2. Dr. I.D. Bajaj
Additional Director General of Health Services
Directorate General of Health Services
New Delhi

1. *Review of Present Status*

1.1 The Rural Health Services in India were developed on the basis of the directions and guidance provided by "Health Survey and Development Committee" (Bhore Committee) in 1946. The Community Development Programme was launched on 2nd October, 1952 as the first integrated rural development programme for all round development of rural areas. It was proposed to establish one Primary Health Centre for every Community Development Block. The Primary Health Centres were conceived as the nuclei from which the Primary Health Care services would radiate through sub-centres, over the countryside. Their operational responsibility as envisaged at that time was to cover medical care, control of communicable diseases, maternal and child health, nutrition, heath education, school health, environmental sanitation and collection of vital statistics. Each primary health centre had three sub-centres, looked after by a trained midwife to provide MCH services.

1.2 The Committee recognised the inter-sectoral efforts required to provide basic health services to the community. Besides suggesting a health system design for the future development of health services in the country, Bhore Committee laid special emphasis on certain basic essentials like suitable housing, sanitary surroundings and provision of safe drinking water. Development of health services were considered as an integral part of the socio-economic development and as such among the recommendations, the Committee also recommended Government's efforts towards elimination of unemployment, provision of living wages for all and improvement in agricultural and industrial production; the concept being stressed now under Alma Ata Declaration.

1.3 The Health Survey and Planning Committee (Mudaliar Committee) 1961 studied the functioning of Primary Health Centres and the progress made in establishing them. To improve the operation of Primary Health Centres, this Committee recommended a reduction in the population covered by them, expansion and strengthening of district hospitals, introduction of mobile teams of specialists to provide necessary supervisory and consultancy services to the periphery.

1.4 The Mudaliar Committee made critical reference to the utilisation of highly trained doctors for carrying out routine duties which can as well as done by lesser qualified people, and suggested concerning such highly trained personnel to jobs that they ought to be doing and to make greater use of auxiliary health personnel. Regarding the health personnel engaged in campaigns against certain diseases, the Committee was of the view that it is neither possible nor desirable to have separate agencies to deal with separate diseases and suggested that health personnel should be trained to tackle all health problems in any area.

1.5 The 1961 census report indicated disturbing trends in size of the country's population, and failure of the "Clinic Approach" to popularise adoption of contraceptive practices. A Committee appointed by Government of India under Mr. R. Mukherjee in 1964 recommended "Extension Approach" and integration of MCH Services with Family Planning Programme. Besides recommending one uni-purpose family planning field worker for every 20,000 rural population and a block extension educator for every primary health centre, the Committee recommended further expansion of facilities at Primary Health Centres with the addition of a rural Family Planning Centre attached to each PHC, one sub-centre for every 10,000 population with a trained Auxiliary Nurse Midwife and one Lady Health Visitor to supervise and guide the work of four sub-centres. Besides adding to the physical facilities and equipment, it was also decided to provide one more medical officer and other supporting staff at each Primary Health Centre. The Committee also recommended to have urban family planning centres for every 50,000 urban population. With the integration of MCH services with family planning programme, the urban centres staffing pattern was revised, so as to include one lady health visitor and one ANM. A pattern of urban family planning centres was subsequently developed to cover different sizes of population.

1.6 The above pattern of developing the rural health and family planning services continued till the Fourth Five Year Plan. The Primary Health Centres complex functioned as centres of medical relief, and first anchor against disease and ill health, and main unit to provide MCH and family planning services in rural areas. They were not equipped either to provide diagnostic facilities, surgical procedures or hospitalization and treatment of serious ailments. The main objectives of health programmes during this period were to (i) control/eradicate communicable diseases; and (ii) provision of curative, preventive and promotional health and family planning services, supply of contraceptive devices. The different important health programmes like malaria, smallpox, tuberculosis, leprosy, MCH and family planning were being implemented in the field as vertical programmes through uni-purpose workers, with little or no coordination among them.

1.7 Primary Health Centres and sub-centres were designed to make primary health care and family planning services available throughout the rural areas. Though most of Primary Health Centres and sub-centres were established according to the plan, they have not been able to effectively cover the entire population under their jurisdiction. The expanded health facilities though achieved some success in control of communicable diseases, provision of MCH services, popularising family planning methods and in providing medical relief, the achievements in all fields were far below expectation. The organisation also did not fulfil its promise of providing primary health care to rural population.

2. *Multi-purpose Workers Scheme*

2.1 The Kartar Singh Committee 1973 recommended establishment of a sub-centre for every 5,000 rural population and integrated approach for delivery of health services by progressively introducing multi-purpose health workers and

supervisors. This scheme attempts to reduce the traditional stratification found at administrative and operational levels of various health programmes. The important manipulative efforts undertaken to modify the policy and strategy of providing primary health care to the rural population involved a rational utilization and adjustment of available health manpower, in such a manner as to reduce the area coverage of peripheral workers and entrust each of them with the responsibility of rendering comprehensive primary health care to the rural community.

2.2 To give effect to this concept, the Fifth Five Year Plan laid stress on the existing uni-purpose workers being trained and re-oriented in the multi-purpose approach. Under this scheme, male uni-purpose health workers like Basic Health Workers, Vaccinators, Family Welfare Health Assistants etc. are designated as Health Workers (Male). The existing Auxiliary Nurse Midwives are designated as Health Workers (Female). Each such worker will work in an area consisting of a population of 5,000. Four such workers (male) will be supervised by a Health Assistant (Male) who is either a Sanitary Inspector, Smallpox Supervisor, Health Inspector, Malaria Inspector etc. and four health workers (female) will be supervised by a Health Assistant (female) who is either a Health Visitor or Public Health Nurse. The team of one male and one female health worker will provide a package of primary health care, including treatment of minor ailments and family planning services to the population of their respective areas, with facilities for referring cases to health assistants and primary health centres. A sum of Rs.2,000 per sub-centre for drugs has been made available to these multi-purpose workers. The expenditure as drug at PHC has been also increased to Rs.12,000 per annum as a part of Minimum Needs Programme. The scheme is planned to be implemented in a phased manner in the rural areas of the country. So far, training programme under multi-purpose workers scheme has been completed in 135 districts and another 143 districts are likely to complete the training by September 1980. The objective is to cover the whole country by 1982-83.

2.3 A committee on "Medical Education and Support Manpower" reviewed the whole situation in 1973 and strongly recommended the speedy implementation of the multi-purpose workers scheme and introduction of a three-tier plan for health care of the villagers, with the community health workers in the village providing the base. It also proposed a plan for reorienting medical education towards the needs of the country, with emphasis being placed on community care rather than hospital care.

Minimum Needs Programme - Its Components

3.1 In order to give priority to the development of rural health services, Government introduced the concept of the Minimum Needs Programme during the Fifth Five Year Plan. The establishment of Primary Health Centres and Sub-centres, upgradation of Primary Health Centres and construction of buildings for PHCs/Sub-centres and staff quarters were included in the Minimum Needs Programme. The establishment of Sub-centres, which uptil now was a centrally sponsored scheme under family planning programme was transferred to the State sector.

3.2 During the Fifth Five Year Plan, the health component of the Minimum Needs Programme consisted of the following:

a. Establishment of one PHC for each Community Development Block.

b. One Sub-centre for every 10,000 population.

c. Making up of the deficiencies in buildings including residential quarters of the existing staff of PHCs and Sub-centres.

d. Provision of drugs *viz.* Rs.12,000 per annum per PHC and Rs.2,000 per annum per Sub-centre. The plan outlays would include only additional funds over and above the level of the expenditure being incurred by the end of Fourth Five Year Plan.

e. Upgradation of one in every four PHCs to 30 bedded Rural Hospital with specialised services in surgery, anaesthesia, medicine, obstetrics and gynaecology. This of course would be in addition to the preventive and promotive health care programme.

3.3 The position of the Primary Health Centres/Sub-centres, targets and achievements during the Fifth Plan is indicated in the following table:

TABLE 1

MINIMUM NEEDS PROGRAMME - PROGRESS AND ACHIEVEMENT DURING THE FIFTH PLAN

Sl. No.	Items under Minimum Needs Programme	Position at the beginning of Fifth Plan 1973-74	FIFTH PLAN		Percentage Achieved
			Targets (Additional) (1974-79)	Achievements (Additional (1974-78)	
1.	Primary Health Centres	5,283	101	117	105.9%
2.	Sub-centres	33,509	10,317	4,606	44.6%
3.	Rural Hospitals	-	1,293	315	24.3%
4.	Backlog of construction of PHCs				
	a. Dispensary buildings with staff quarters	602	918	218	23.7%
	b. Dispensary buildings only	3,813	552	132	23.9%
	c. Staff quarters only	1,154	3,211	591	18.4%
	d. Backlog of construction of sub-centres	18,047	15,462	3,491	22.5%

3.4 During the Fifth Plan it was planned to establish 101 new PHCs; 10,317 sub-centres (to have one sub-centre for every 10,000 population) and 1,293 Rural Hospitals (by upgrading 25 per cent of the PHCs), to link the referral services and provide the specialized services in the rural areas besides making up the deficiencies in buildings, staff quarters, equipments and drugs at enhanced rates at these centres. As against these targets, the achievements upto 1977-78 have been dismal leaving considerable backlog in the establishment of upgraded hospitals and sub-centres. Likewise there was a large backlog in the construction work. The progress achieved in the construction of staff quarters was minimum *viz.*18.4 per cent while in the other construction works, the achievement was 22 to 24 per cent only.

4. *Community Health Workers Scheme**

4.1 In keeping with the objective to provide better health facilities to the rural population, with the involvement and participation of the Community Health Volunteers, a Scheme was launched on 2nd October, 1977. The scheme began with the training of community health workers in 733 selected primary health centres spread over the country. Structured around the central philosophy of "placing people's health in the people's hands", the Scheme envisages the provision of one community health worker for every village or community with a population of 1,000.

4.2 The Government introduced the CHV Scheme in view of the recommendations of the Srivastav Committee and experience gained through large number of health projects tried successfully in different parts of the country. The objective of the scheme is to make both preventive and promotive primary health care facilities along with treatment of minor ailments, available to every villager. It is proposed that for this purpose one community health worker will be provided for every one thousand population or approximately one per village. About 1,30,000 community health workers have been trained so far and are serving the rural population.

5. *Sixth Five Year Plan - Revised Minimum Needs Programme*

5.1 During the Sixth Plan, under the Revised Minimum Needs Programme, it is proposed not only to eliminate the above mentioned shortfalls/backlogs, but also to extend the physical infra-structure in the rural areas as per following norms:

a. Establishment of additional 178 PHCs.

b. Establishment of one Sub-centre for every 5,000 population by 1987-88 (71 per cent of the target is to be achieved by 1982-83).

c. All uni-purpose workers in Primary Health Centres are to be converted into multi-purpose workers.

d. Two workers to be provided for every 5,000 population.

*Now called as Community Health Volunteers Scheme.

e. One Community Health Volunteer to be provided in each of the village.

f. One trained *dai* to be provided in every village.

5.2 So far as the tribal areas are concerned, the Planning Commission has agreed in principle to provide one PHC for 20,000 population and a Sub-centre for 3,000 population in the tribal areas.

5.3 The following table indicates the backlog as in the end of 1977-78 and the targets for the Sixth Plan (1978-83):

TABLE 2

MINIMUM NEEDS PROGRAMME - BACKLOG IN 1977-78 AND TARGETS IN THE SIXTH PLAN

Sl. No.	Items under Minimum Needs Programme	Position in the beginning of the Sixth Plan 1977-78	Backlog as in the beginning of Sixth Plan 1977-78	Targets for Sixth Plan 1978-83
1.	Primary Health Centres	5,400	Nil	178
2.	Sub-centres	38,115	5,713	38,566
3.	Rural Hospitals	315	978	545
4.	Backlog of construction of PHC			
	a. Dispensary buildings with staff quarters	820*	700)	Full coverage of functional buildings and composite buildings and 50% of staff quarters
	b. Dispensary buildings only	3,945*	420)	
	c. Staff quarters only	1,745*	2,620	1,310 (50% of backlog)
	d. Backlog of construction of Sub-centres	21,538*	11,971	5,985 (50% of coverage)

*Position of construction in respect of units opened during Fifth Plan not available.

5.3.1 So far (upto 30th September, 1979), 71 PHCs out of a target of 178 (as conveyed by the State) have been established. In other words, 39.8 per cent of the target has been achieved. Twenty-eight more PHCs are likely to be established by 31st March, 1980.

5.3.2 In the Sixth Plan (upto 30th September, 1979), 8,094 Sub-centres have been established against a target of 38,566. In other words, 20.9 per cent of the target has been achieved. Three thousand one hundred and fourteen more Sub-centres are likely to be established by March 31, 1980.

5.3.3 On 30th September, 1979 out of 5,471 PHCs in position, 3,643 (66.5 per cent) were with buildings. Out of 46,209 Sub-centres functioning, 21,538 are functioning with buildings at the beginning of present plan. During the Sixth Plan the target is to construct 50 per cent of the backlog *i.e.* 5,985 buildings.

5.3.4 During the Sixth Plan, 545 PHCs are to be upgraded to 30 bedded rural hospitals. At the end of the Fifth Plan, 315 rural hospitals were established. During the year 1978-79 and 1979-80, 344 rural hospitals have been sanctioned. The construction of buildings, posting of additional staff and provision of equipments for these new upgraded PHCs are in different stages of implementation

5.4 The multi-purpose workers programme implementation is being toned up to progress a little ahead of the community health workers programme in order to provide an effective organisational and referral framework. It is envisaged that by the end of the Five Year Plan period 1978-83 there will be one male health worker and one female health worker for every 5,000 of the population. The integrated health care programme covering the various components of health, family welfare, nutrition, maternity and child health etc. will be through these personnel specially trained for the purpose.

5.5 The Primary Health Centres will serve as neighbourhood hospitals with referral linkage to 'intermediate' and district hospitals. In order to reorient medical education towards the needs of the country and community care, three primary health centres are being attached to each of the 106 medical colleges.

6. Under the family planning programme 1,000 PHCs have been provided improved physical facilities and additional surgical equipment to undertake tubectomy operations, MTP procedures, and to provide better services to obstetric cases. Three hundred and twenty five sub-divisional level hospitals have also been provided additional beds and surgical facilities.

7. Beside the above infra-structure, there are large number of dispensaries providing medical care in the rural areas. It is estimated that there are about 11,000 such dispensaries of ayurvedic, unani, siddha and homoeopathy and about 5,000 dispensaries of allopathic system run by Government and local bodies.

8. *Perspective Plan of the Government*

8.1 It is estimated that by the year 2000 A.D., the population of India would increase to 917 million - 674 million rural and 243 million urban. The subsequent five year development plans of the country would take into account the need of health infra-structure required for the delivery of primary health care to this increased population. The health infra-structure envisaged would be as follows:

8.2 The Government has already accepted the policy of creating a band of voluntary health workers by training persons selected by the community under the Community Health Workers Scheme. It is proposed to train about 5.8 lakh CHWs during the present plan period 1978-83, so as to have one CHW for every village.

8.3 The *dais* (indigenous birth attendants) training programme has already been intensified and it is proposed to train 5.8 lakh *dais* by March 1983 so as to have one trained *dai* for every village. Realising that in large number of villages, there is more than one *dai* functioning at present and each *dai* is traditionally attached to only limited number of families, the *dais* training programme would be continued beyond 1983, with the aim of training all the *dais* practising in rural areas.

8.4 It has been accepted to have a health sub-centre with one male and one female multi-purpose worker for every 5,000 rural population. There were about 39,000 sub-centres by the end of Fifth Five Year Plan (March 1978). A provision has already been made to have additional 38,000 sub-centres during the plan period 1978-83 and another 40,000 sub-centres during the plan period 1983-88. Based on the present norms, country would need about 1,40,000 sub-centres by 2000 A.D. which would mean establishment of 23,000 additional sub-centres after 1988.

8.5 The concept of having subsidiary health centres has not yet been adopted on an uniform basis. Every Primary Health Centre area has two-three or even more dispensaries of allpathic/ayurvedic/homoeopathic system. More and more such dispensaries are being opened. It is envisaged under the MPW Scheme to have one male and one female health assistant at one out of every four sub-centres (one male and female assistant for 20,000 population). It was proposed under the Minimum Needs Programme during the Fifth Five Year Plan that all the dispensaries functioning in rural areas should be brought under the PHC Complex.

Future subsidiary health centre envisaged would consist of staff of present dispensaries, one health assistant female, one health assistant male, and one male and one female multi-purpose workers. For this purpose, sub-centres with headquarters of health assistants under the present expansion programme would first be located and integrated with the dispensaries presently functioning in rural areas. These subsidiary health centres would undertake all the functions for about 25,000 population, which at present are being carried out from the PHCs.

8.6 At present Primary Health Centres form the nucleus of providing health services in rural areas. These are about 5,471 PHCs functioning at present in the country, each covering a population between 30,000 to 1,25,000. It has been found that these PHCs are unable to provide adequate health coverage to such a large segment of population. The Planning Commission has already accepted in principle to establish additional PHCs from 1983 onwards in a phased manner so as to have one PHC for every 50,000 population. At present each PHC complex has two components - one health unit created under the original PHC pattern and a rural family welfare centre added under family

welfare programme. No decision has yet been taken whether the new PHCs to be opened in future would also have a rural family planning centre attached to it.

8.7 In order to provide back up referral services, it has been decided to upgrade one out of every four PHCs or a sub-district hospital into a rural hospital, with 30 beds and common specialities of surgery, obstetric and gynaecology and paediatrics.

CHAPTER 2

Strategy

1. While assessing the capacity of proposed health infrastructure to provide health for all and working out the health organisation required to achieve the ultimate goal of effectively providing primary health care to the community, the Group followed the following guiding principles:

1.1 The urban poor and slum dwellers are in as much need of primary health care services as the population in rural, tribal and hilly areas. While the successive two-year development plans took special care to provide a systematic health organisation for rural areas, no such plans were followed in case of building up a health organisation for urban areas.

1.2 A vast network of health infrastructure has been built up during the last thirty years and as such it would be unwise to make any drastic departure and suggest a new set up. On the other hand it would be possible to revamp the infrastructure already established to suit the future needs.

1.3 In a vast country like ours it would not be possible to stick to a rigid pattern, and as such any health organisation proposed should have enough facilities for adoption in different areas of the country; at the same time it should be enough rigid as far as basic principles and achievement of ultimate objectives are concerned.

1.4 For sometime to come, high incidence of malarial and infant mortality, family planning, environmental sanitation, malaria, tuberculosis, leprosy and the other communicable diseases and diarrhoeal diseases would continue to be the major health problems of the country. Any health organisation should be effective in tackling these health problems, at the same time should be adoptable enough to meet any health challenges of the future.

1.5 The proposed health organisation should be within the means and financial resources of the country.

1.6 The health organisation must have the faith and confidence, through its active involvement and participation.

1.7 Para-professionals, auxiliaries and community health workers are capable of shouldering much greater responsibilities and as such full use should be made of their potential.

1.8 There is absolute need to re-organise the Directorate General of Health Services, State Directorate of Health Services and District level health organisations to provide effective leadership.

1.9 Responsibilities can effectively be shouldered only when coupled with appropriate powers and as such more and more financial and administrative powers should be delegated to peripheral organisations.

1.10 The preventive and promotive aspects of health care should be subgraded with all the institutions which are only providing medical care at present.

1.11 Voluntary and private health sector has an important role to play and as such full advantages should be taken of their potentialities.

1.12 Provision of strong back up referral services is essential to have the community's confidence in the primary health care delivery organisations.

1.13 In spite of its best efforts and intentions, it would not be possible for Government alone to provide all the financial requirements under present state of country's economy, as such community must share some of the cost of health care delivery.

1.14 Health institutions of all systems and trained manpower available under different systems of medicines should be fully involved in the delivery of primary health care.

1.15 The cost of health organisation can appreciably be brought down with the adoption of appropriate technology.

1.16 In order that the medical profession provides dynamic leadership to the whole health team, and pays special consideration to the health needs of weaker section of the community irrespective of their paying capacity it is inescapable that private practice by the doctors in government service is banned.

1.17 A programme of continuing education is essential to keep the whole health team effective and efficient.

1.18 Health education of the community cannot be a sole responsibility of the health functionaries or health organisations. It should form an integral part of all formal, informal or functional educational programmes.

2. *Health Organisation*

2.1 Village Level

2.1.1 The group feels that certain minimum basic facilities must be made available in every village to provide

- Treatment of minor ailments
- First-aid during emergencies and accidents
- Health education about environmental sanitation and personal hygiene

- Education and motivation about family planning

- Distribution of Conventional Contraceptives

- Preventive measures against communicable diseases

- Ante-natal, peri-natal and post-natal services

- Nutrition education

- Infant and child care

- Any other local health needs

2.1.2 It would have been ideal if each village could have a health post with a male and a female health auxiliary. However, keeping in view the trained manpower required and its financial implications, it may not be possible to achieve this goal within the next 20 years. It would need the immediate needs of the community if someone from the community is trained to provide these services on part-time basis.

2.1.3 Some of the required services are at present being provided by the community health volunteers. This scheme needs all the encouragement and further expansion to cover all the villages in the country. However, realising the socio-economic variations in different States/Union Territories of the country and the fact that certain States and Union Territories have not agreed to implement the CHV Scheme, the Group is of the view that States/ Union Territories may be given the flexibility in working out the details of the scheme, as large as the basic principles of services to be provided, availability of the services all the time and involvement of local community in any arrangement proposed for this purpose, are not compromised. The scheme should be implementable within the resources available. It was also felt that rendering such type of services through mobile service team would not meet the health needs of community, which are likely to be more concerned with the curative service and are not likely to be useful for preventive and promotive health aspects.

2.2 Sub-Centre Level

2.2.1 According to the plan of the Government of India, it is proposed to have one sub-centre with one male and one female multi-purpose worker for every 5,000 population. Though there are large number of studies to indicate that one sub-centre for 5,000 population is inadequate to meet the health requirements of the community, the Group is of the view that keeping in mind the large number of the additional sub-centres which would be required to be established even to achieve this norm, any suggestion to have large number of sub-centres may not be practical. However, the ultimate aim should be to have one sub-centre for 2,000-2,500 population and sincere efforts should be made to increase the number of sub-centres once the presently fixed norm at one sub-centre for 5,000 population in general and one sub-centre for 3,000 population in tribal and hilly areas is achieved.

2.2.2 The Sub-centre is the most peripheral health unit and first contact point between the community and Government health set up, as such it has a private role in providing primary health to the population. Government realising the importance of sub-centres has given a high priority to them by including the establishment of sub-centres under the revised minimum needs programme. The Government plan envisages establishment of over 36,000 sub-centres during the plan period 1978-83 and another 40,000 sub-centres during the plan period 1983-88, to achieve a norm of one sub-centre for 5,000 population by 1988. However, the progress in this direction, inspite of the high priority given by the Government is rather disappointing, and it is doubtful that with the present pace the number of the sub-centres planned, would be established.

2.2.3 The difficulties in establishing sub-centres and their effective working are well known. Under the circumstances, the Group suggests the following procedures to be adopted for the establishment of new sub-centres:

i. First the new sub-centres be established with existing dispensaries (allopathic/ayurvedic/unani/siddha/homoeopathic);

ii. The States may be requested to decide the Group of villages to be covered by each new sub-centre;

iii. The community of these groups of villages should be requested to select and recommend suitable men and women belonging to one of these villages for training as MPWs;

iv. These candidates recommended by the community should be trained and permanently posted as MPWs in their own village; and

v. The sub-centre should be located in the village to which the MPW (female) belongs, and the community should be asked to provide the building for the sub-centre. The Government should provide an assistance of Rs.15,000 to the village for this purpose.

2.4 The advantages of adopting these procedures for establishing new sub-centres are likely to be:

a. full involvement of the community;

b. getting over the problem of female MPWs as the woman would be belonging to the same village, she would be having her own residence and would be fully secured working in her own people;

c. the unit cost would come down, as there would be no need to construct residence portion of sub-centre. There is likely to be further saving as it may not be necessary to provide a part-time attendant to the MPW (F) for accompanying her during her field visits; and

d. the suitable sites for constructing sub-centres would be easily available and buildings would also come up fast, as they would be constructed by local community and would be considered as their own.

The community would be also more interested in maintenance of these buildings.

2.2.5 The Group also feels that the MPW (F)/ANMs are trained and are capable of rendering much better services to the community than they are doing now, provided necessary facilities are extended at the sub-centres which should be strengthened by the following facilities:

i. Adequate provisions for linen, dressings and facilities for auto-cleaning and sterilization of equipment, so that duties may be conducted by proper specific procedures;

ii. Facilities for doing IUD insertion;

iii. Practical demonstration for nutrition education;

iv. Adequate quantity of drugs and dressings to provide treatment of minor ailments;

v. Weighing machines, educational material, record forms and registers etc.; and

vi. Proper sub-centre building to carry out above functions (group learns that no provision has been made to construct buildings at the additional sub-centres proposed to be established during 1978-83).

2.3 Intermediate PHC Level

2.3.1 The Government has already decided to have one primary health centre for 50,000 population in the plains and one primary health centre for 20,000 population in tribal and hilly areas. According to these norms about 14,500 sub-centres would be required by 2000 A.D. or in other words an additional 9,000 primary health centres to be established in the next 20 years. The setting up of new primary health centres is proposed to be undertaken from the year 1983 onwards.

2.3.2 There are about 11,000 dispensaries of indigenous systems of medicine and 5,000 dispensaries of allopathic system providing medical care services in the rural areas at present. Though there has been no plan of establishing all the dispensaries and they do not form a component of the Government's Minimum Needs Programme, the clamour and demand for curative services has led to opening large number of these dispensaries irrespective of any systematic approach. These dispensaries are in no way either linked with the sub-centres below or to the primary health centres above. They are functioning in isolation and do not provide any preventive, promotive and rehabilitative health services.

2.3.3 The Group feels that instead of opening new primary health centres which would require large financial allocations all the existing dispensaries in rural areas should be upgraded to primary health centres to achieve the

norms fixed for this purpose. In order to avoid any conflict among the various systems of medicine it is suggested that the curative services from these new primary health centres would be through the system of medicine to which these dispensaries belong at present. The Group strongly feels that in future no more dispensaries should be opened as they fail to function as institutions which take care of the total health needs of the population. Even converting all these dispensaries into primary health centres is a gigantic task and calls for large allocation of funds. This development should be undertaken in the phased manner. As a first step one of the dispensaries in the PHC area which covers a population of over one lakh should be upgraded to primary health centres by 1985, so that by the time no PHC covers a population of over a lakh. Second phase should be to provide additional PHC in the area which covers a population between 75,000 to one lakh and during the third phase all the PHCs which cover more than 50,000 population should have another PHC

2.3.4 The Group is also of the opinion that the working of the present PHCs can further be improved and service facilities increased particularly in respect of Maternal and Child Health services for MTP, male and female sterilisation, attending to simple complications in obstetrics cases and in respect of laboratory services. For this purpose it would be necessary to provide additional facilities at the existing primary health centres and to get the medical officers and other auxiliary staff trained for the purpose.

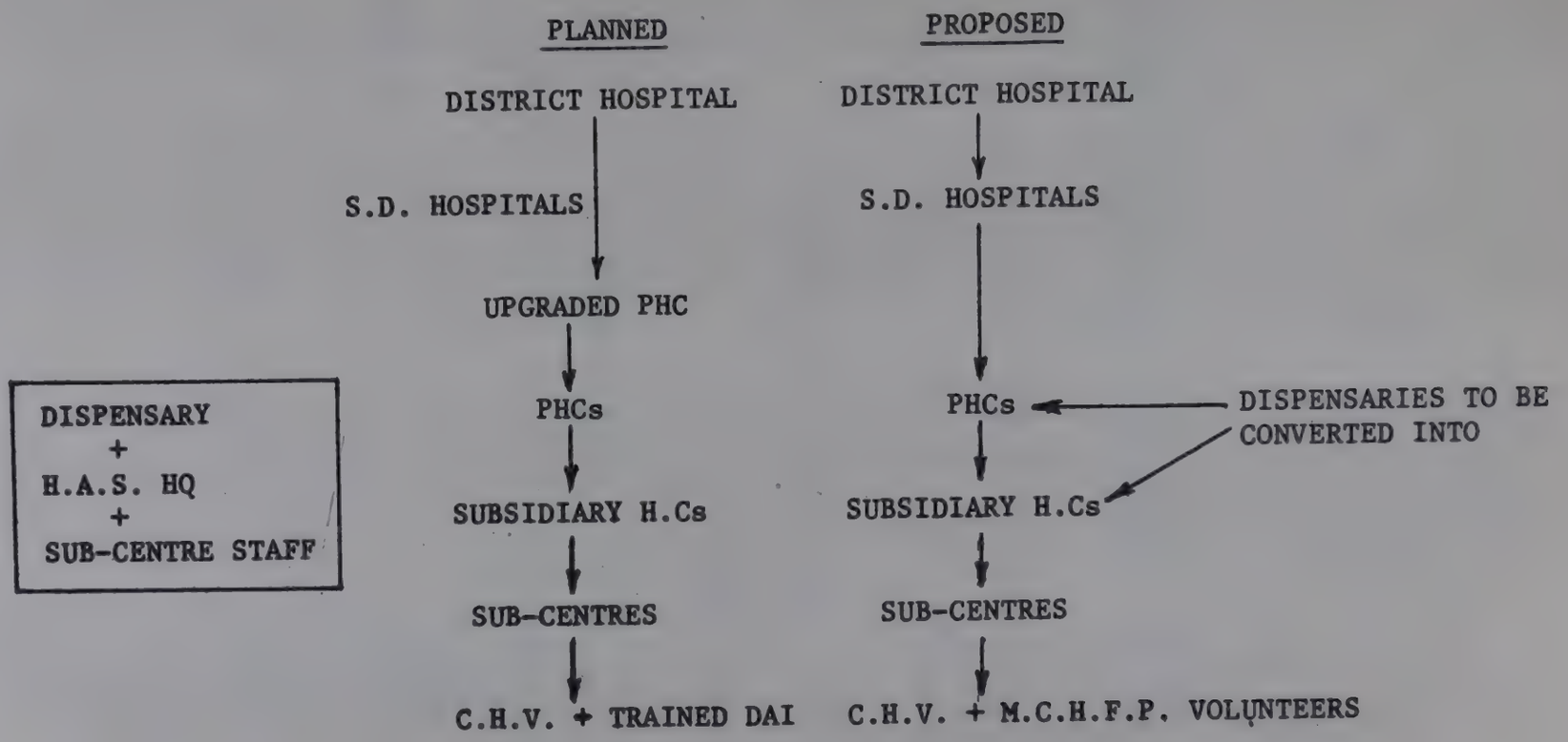
2.4 Upgraded Primary Health Centres

The Government has accepted the need to upgrade 25 per cent of the Primary Health Centres into upgraded PHCs to provide first point of referrals. It is estimated that on the present accepted ratio of one upgraded PHC out of every four about 3,700 Primary Health Centres would require to be upgraded. The Group also took into consideration that at present there are about 2,000 hospitals functioning at the sub-district level (sub-divisional/tehsil/taluq hospitals). These hospitals to some extent have got facilities varying from area to area. It is felt that the communication between these hospitals and Primary Health Centres in the rural areas are much better than between PHC to PHC. Further providing necessary additional inputs in these sub-district hospitals to make them effective as a first referral would be much cheaper than to upgrade the Primary Health Centres. As such the Group strongly feels that instead of upgrading the Primary Health Centres the existing sub-district hospitals may be provided additional inputs to bring them at par with the proposed upgraded PHC. However, for the additional number of upgraded PHC required and in places where sub-district hospital does not exist one of the Primary Health Centre may be upgraded.

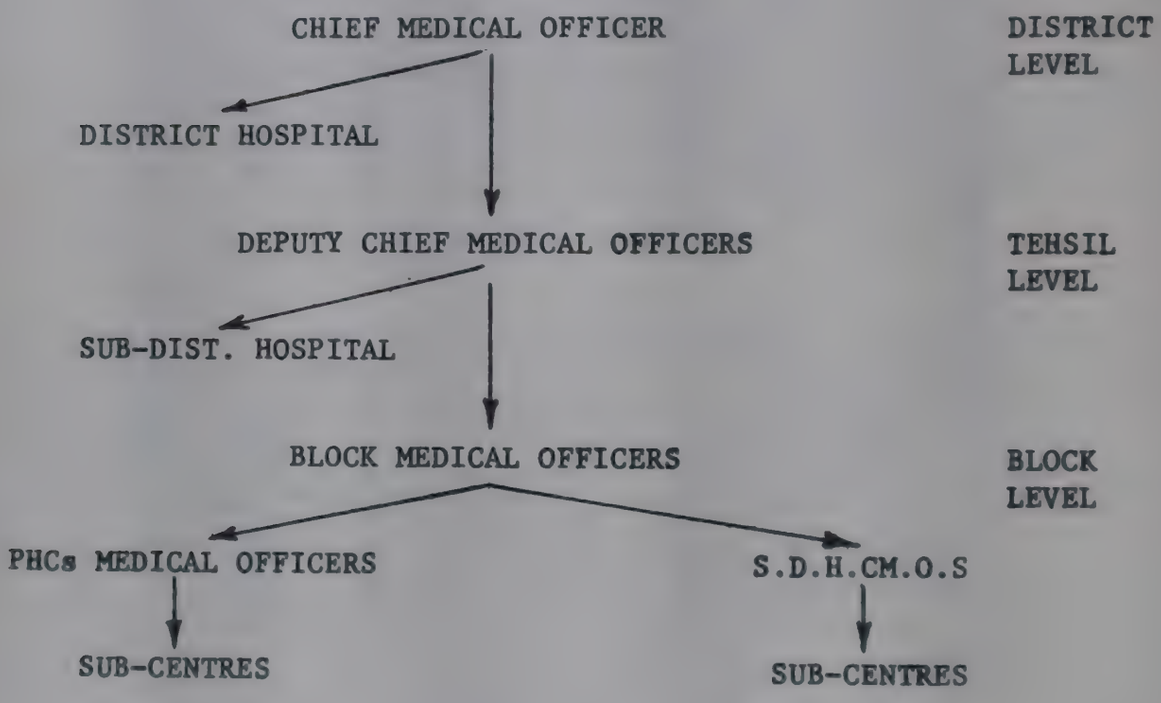
2.5 District Level

2.5.1 The District Level Health Organisation has been developed piece-meal according to the needs of the individual programme in past. There is a uniform set up at the district level irrespective of the size of the district or the number of PHCs located thereunder. With the integration of the services and their expansion, Group feels that the District Health Organisation needs to be reorganised on the basis of the number of PHCs covered by it and staffing pattern rationalised to provide greater supervision and technical guidance.

HEALTH ORGANISATION



HEALTH ORGANISATION - DISTRICT LEVEL AND BELOW



I. SUGGESTED ORGANISATION IN DISTRICTS WITH 8 OR LESS PRIMARY HEALTH CENTRES

CHIEF MEDICAL OFFICER

	Technical Wing	Extension Education & Media Wing	Transport Wing	Statistics & Evaluation	Administration
Medical Officer Incharge District Hospital	Dy. C.M.O. 1	Dist. Media & Extn. Education Officer 1	Vehicles 3	Statistical Assistant 1	Office Supdt. 1 Asst. Accountant 1
Existing set up	Medical Officer 1	Extn. Educator 1	Drivers 3		
	Public Health Nurse 1	Projectionist 1	Mechanic 1	Computor 1	Cashier 1
	Malaria Inspectors 4	L.D.C. Typist 1	Cashier 1		Store Keeper 1 U.D.C. 1 L.D.C./Typist 2 Steno-Typist 1 Sweeper 1 Chowkidar 2

In addition: (In all districts wherever at present sanctioned)

Malaria Sup.
- Field Workers (Malaria) - 12
- Field Workers (Malaria) - 12
- Surveillance teams (Malaria Spray Team (Malaria)

Laboratory Technician
Treatment organiser
B.C.G. Team Leader
Class IV - 2

T.B. Programme: Second Medical Officer T.B.
X-Ray Technician

Leprosy - Leprosy Control Unit

2.5.2 While recommending the reorganisation of the district level health set-up the Group has taken the following criteria into consideration:

1. The district level Health Organisation is according to the size of the district, number of PHCs being the criterion.

2. The technical staff is engaged more in technical supervision than in the administrative work.

3. The field level supervision from district level is strengthened.

4. Other technical staff beside the doctor is given greater responsibility.

5. Mass Media, education and motivation activities for FW and MCH and health education activities are strengthened.

6. The job responsibilities of each district level functionaries are clearly redefined.

7. The existing district level staff is better utilised and streamlined, without appreciably increasing financial liability either for the Central or State Governments.

8. The proposed district level organisation is in line with the accepted policy on multi-purpose workers scheme and is able to provide greater support for the success of these schemes.

2.5.3 Under the Multi-Purpose Workers Scheme, it has been suggested to the States to have integrated set-up at district level by having a Chief Medical Officer of the district with three Dy. (existing Civil Surgeons, District Health Officers and District F.W. Officers) with each of the Dy. CMOs being incharge of one-third of the district for all the Health, F.W. and MCH programmes.

2.5.4 The Group recommends that the District Level Health Organisation for district having eight or less PHCs should be as given on page 109.

For the districts with more than 8 PHCs, Group is of the opinion that besides the organisation suggested for the districts with eight or less PHCs, the following additional staff should be provided for each State of eight or less PHCs:

1.	Dy. Chief Medical Officer	1
2.	Public Health Nurse	1
3.	Extension Educator	1
4.	Senior Sanitarion	1

5.	Malaria Inspector	1
6.	Projectionist	1
7.	U.D.C.	1
8.	L.D.C.	1
9.	Driver	1
10.	Peon	1
11.	Vehicle	1

2.5.5 These units should function from the sub-district level, for effective control and supervision.

2.5.6 At present the district level organisation is financed under different schemes. It is recommended that while the present financing pattern may continue, the marginal financial implications of the suggested re-organised pattern may be met on 50:50 basis by the Central and State Governments.

2.6 State and Central Level

2.6.1 The State Directorate of Health Services and Directorate General of Health Services at Central level were organised keeping in view the development of vertical programmes. With the integration of services at the peripheral level it seems necessary now that the Directorate of Health Services and Directorate General of Health Services are re-organised to provide effective guidance and to monitor the development of health services in a coordinated manner. The Group feels that all the health services should be headed by one Chief Director of Health Services. The tendency in certain States to have separate Directors for Health and Medical Services and Medical Education is not conducive to effective and coordinated functions. The Directorates are functioning in most of the cases on the basis of individual and not on the basis of activities. This has resulted in each programme section carrying on the same type of activities in parts with not a little coordination. This type of functioning beside being costly and wasteful adversely affects the smooth functioning of district and other peripheral units.

2.6.2 The Group recommends the re-organisation of Directors of Health Services and Directorate General of Health Services on activity basis. The general pattern of this organisation suggested is to have in directorates, divisions, each headed by an Additional Joint Director and assisted by other Junior Officers.

i. Budget

ii. Planning

iii. Health Manpower Development and Training

iv. Health Information and Intelligence

v. Transport

vi. Administration and Establishment

vii. Purchases and Supplies

viii. Services and Programmes

2.6.3 Services and programme division should be headed by the officer next only to the Director. All the programme officers/incharges of individual programmes/specialists should be part of the services and programme division. This would ensure proper coordination amongst the various programmes, which are to be implemented by common functionaries in the field. This would also ensure proper priorities and balance among various programmes and avoid excessive emphasis on any one programme at the cost of other.

3. *Training*

3.1 While reviewing the training facilities and training programmes for various categories of health workers and health administrators, the Group feels that there is a need for strengthening training programmes and recommends that:

i. There is an immediate need for including the administrative and management aspects in various training curriculum. As none of the staff has yet been exposed to this type of training, the training load is exceptionally heavy. In order that these elements of training are integrated with the present training programmes, the various basic and orientation training centres should be suitably strengthend to have training faculty for these aspects of training.

ii. Similarly, district and block level staff responsible for educational activities did not have any worthwhile training uptil now in techniques of communication and health education. Most of the Central Training Institutes and Health and Family Welfare Training Centres are ill-equipped to impart this type of training. These Centres should immediately be strengthened by providing necessary facilities and faculty for imparting training in communication and health education.

iii. Large number of multi-purpose workers (male) would have to be trained to meet the requirement of one worker for every 5,000 population. There is no basic training programme for these workers. It is necessary that required basic training facilities are created by establishing new training schools for MPWs (male), so that required number of trained workers are available to have one MPW (male) for every 5,000. population by the end of 1987.

iv. The training programmes for various health functionaries needs to be multi-disciplinary, constantly reviewed, modified and strengthened. These functions must be taken over by certain selected institutions. It is desirable that some of the Central Training Institutions are reorganised and converted into "Institutions of Health Sciences", with following functions:

a. Undertake training programmes for all the categories of health

personnel, to review, modify, strengthen the existing training programmes and to provide feedback;

b. Participate in planning, implementation and evaluation of basic training programmes;

c. Undertake training of the trainers and provide guidance to the peripheral training institutions;

d. Development of training methodologies, training aids and materials;

e. Operational research studies on Primary Health Care system and in training and utilisation of Primary Health Care Workers;

f. Evaluation of the impact on Primary Health Care services on the health status of the community;.

v. The leadership of the health team is in the hands of the Primary Health Centres. Medical Officers, who are ill-equipped to shoulder this responsibility in the absence of any administrative and management training during their medical studies. Therefore, it is desirable to have a pre-service training programme for the doctors, freshly recruited for posting at the Primary Health Centres.

vi. The Group noted with concern the lack of appreciation of community health problems among the district, State and Central level health administrators. This is particularly so, when an officer from the curative disciplines is straightaway promoted as health administrator by virtue of his seniority in service. The Group strongly recommends that all the health administrators should be exposed to a staff college-type training in health administration before taking up their new assignments. Such type of course should be carefully drawn out and should be a regular activity of National Institute of Health and Family Welfare, New Delhi; and All India Institute of Hygiene & Public Health, Calcutta.

3.2 Continuing Education

The need and importance of continuing education for all categories of health personnel cannot be over-emphasised. Unfortunately, there is no provision for the continuing education of most of the health personnel. The programme drawn out by the Ministry for the continuing education of multipurpose health workers and community health volunteers is also not being implemented to the desired extent. The Group recommends that the Government should ensure the implementation of the existing programme and in addition should work out a scheme, so that the basic training institutions take up the continuing education programme as a part of their normal functions. This can be done with only addition of certain physical facilities in the existing institutions. For this purpose the Group recommends:

a. Continuing education of CHVs, *dai* and MPWs (male) should be a regular function of PHCs staff on the lines already suggested by the Government.

b. ANMs and Health Assistants (female) should be given 10-15 days continuing education every year in the existing ANM and Professional Training Centres. Each centre would have a workload of 100-150 candidates every year. The candidates may be taken in batches of 10-15 for this purpose.

c. The services of Sanitary Inspectors Training Centres and Health and Family Welfare Training Centres should be utilised for the continuing education of Health Assistants (Male).

d. Similarly, all the medical colleges should be entrusted with continuing education of medical officers of PHC, which may be of about 15 days duration every year.

3.3 Besides the health personnel in public sector, the health personnel working in private and voluntary sector also needs continuing education. It is suggested that the government should encourage and support the various professional organisations/councils/associations to undertake such activities. The facilities of public sector, should also be made available to these personnel, wherever possible.

4. *Referral System*

4.1 To ensure that the peripheral health personnel/organisation enjoys the confidence of the community, it is essential that it is given the support of higher level health personnel/organisation, which have the technical knowledge and technology which is too complex or costly to be available routinely through primary health care. While some sort of referral system does exist between peripheral workers and PHCs, either there is no linkage between PHCs and higher institutions, or the linkages are so weak that they are ineffective and fail to carry the confidence of the community. The higher health institutions at sub-district, district, regional, State and Central level should review the functioning and prepare themselves to provide necessary facilities to the cases referred from peripheral institutions. It would be desirable if the procedures of referrals at each level are clearly laid down and referral services become the most important functions of these institutions.

4.2 In order to have the best utilisation of limited specialised institutions in the country, the Government should seriously consider declaring certain institutions exclusively for referral services. This will ensure that their facilities and expertise is available only to those, who really need them, and are not wasted on providing services to those, who can get required services at other lower levels.

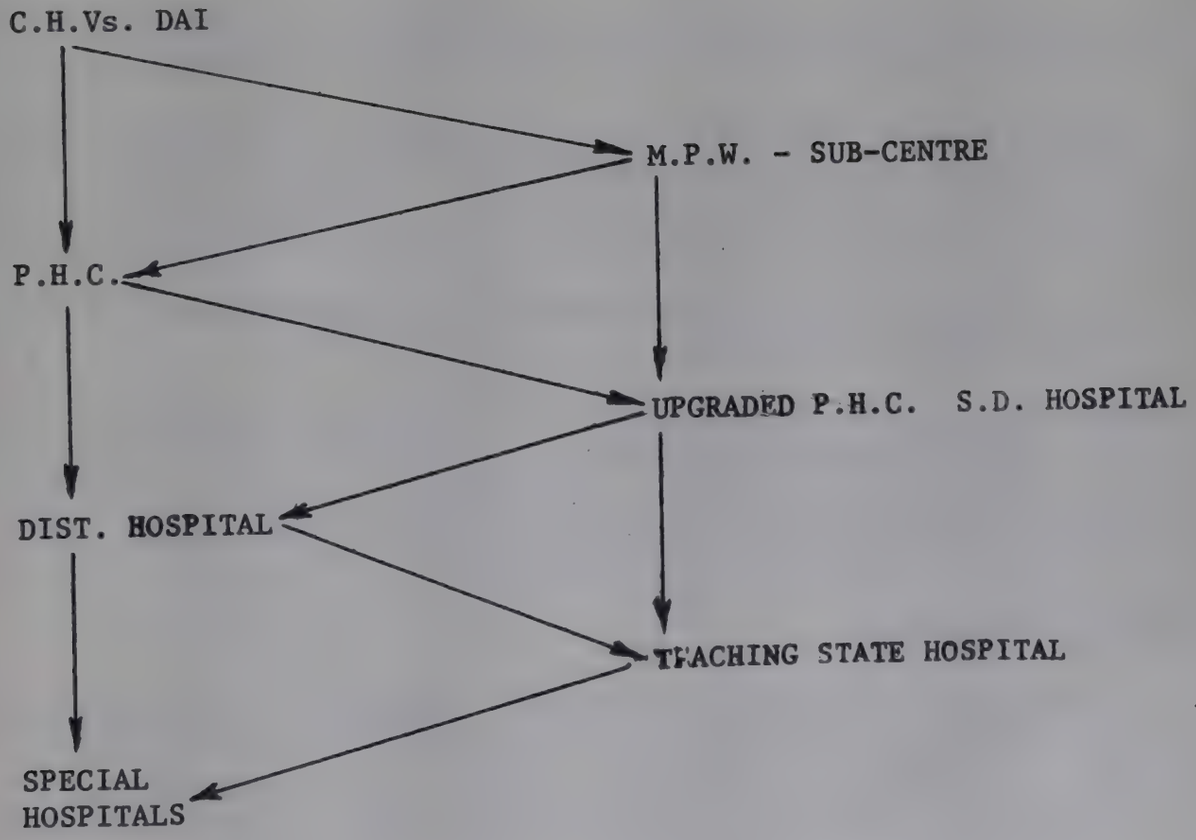
4.3 The transportation of the patients to and from referral has to be properly organised, making the most of the available facilities.

4.4 It should be emphasised that referral is a two-way process and that the retention of patients in a referral institution should be as brief as possible. There would be large number of referrals, which require only certain investigations, diagnosis and line of treatment, which can be carried out at

Primary Health Centres with guidance concerning the further care required. It would be desirable if all higher level institutions keep few days in a week specifically for attending to the referral cases, so that they can be examined, investigated and referred back to the referring institution by the same day.

4.5 The referrals should not be automatic to the next higher level, instead the referring institution should be free to refer the cases, to the institution, which in their opinion has the necessary facilities for providing competent services, required by the case. The Group recommends the referral linkages as given in the flow-chart hereunder and suggests the formalisation through appropriate administrative orders. No doubt certain institutions would need additional inputs to be effective as referral institutions, but the Group feels that within the limited resources first priority should be given to put in position the peripheral organisation required for providing the primary health care and strengthening of district hospitals and higher level institutions should be taken up only if and when the resources permit such strengthening after meeting the needs of peripheral organisation.

REFERRAL SYSTEM



5. *Financing the Health Services*

5.1 The Group while considering the Health Services Organisation has been throughout guided by the fact that any organisation recommended should be implementable without too much disturbing the existing structure. It should be also within the means and resources which can be mobilised. Keeping this in view, the Group has even suggested changes in the accepted plan of the Government in setting up sub-centres, primary health centres and upgraded PHCs. Inspite of these precautions and considerations, it is extremely doubtful that the present pattern of resource allocations can establish a minimum health organisation considered absolutely essential to meet the basic health needs of the community by 2000 A.D. This would also mean setting up of the health service organisation at least by the year 1990, so that it gets at least 10 years to bring about necessary changes in the health status of the community in next 10 years. No doubt the primary responsibility of providing health services to the people is that of the Government. It seems that under the present socio-economic conditions, it may not be possible for the Government alone to take up the total responsibility. The Group feels that inspite of these constraints the objectives of Health for All by 2000 A.D. are achievable with the active involvement of voluntary and private sector, maximising the resources, making the affording section of the community to share some of the cost, and selective approach so that the needs of vulnerable group of population and those who cannot afford are met first. In this regard, the Group recommends the following measures for the consideration of the Government:

5.2 For Maximising the Available Resources

i. Integration of health services organisation on the basis of activities instead of on the basis of individual services/programmes.

ii. Bringing similar components of the programme/organisation under one budget head, like MPWs, sub-centres etc. This would improve the efficiency of the organisation and much time at present wasted on administrative procedures, can be better utilised for programme development.

iii. Bringing down the cost of construction and equipment by the use of locally available material.

iv. Restricting the free availability of medicines from PHC upwards only under National Health Programmes, to vulnerable group of population and in cases of accidents and emergencies. As an alternate only certain basic medicines are made available at each level, and others may be purchased by the patient.

5.3 Community Resources

i. Requiring the community to contribute towards the construction of sub-centres, subsidiary health centres, PHCs and upgraded PHCs. This contribution may be in the form of free land, manpower, cost of material, equipment etc. In fact many States are already taking community's contribution in one or the other forms.

ii. Charging nominal fee for investigations, diet provided in hospitals, medicines.

iii. Providing paid services, indoor and outdoor, to affording persons in public hospitals, without any part of such income going to the staff.

iv. Charging nominal fee from every new out-patients and indoor patients.